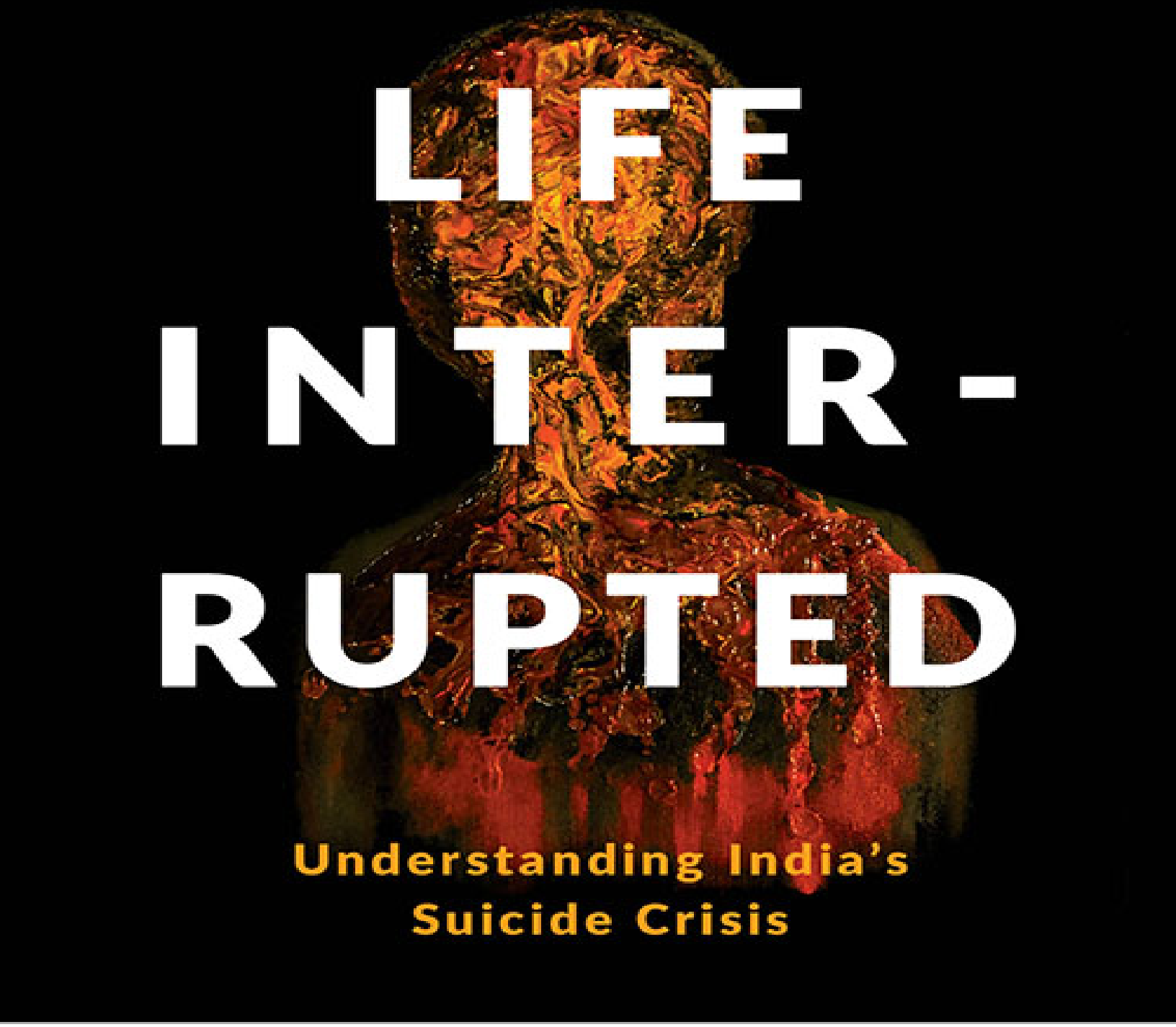
"A timely book that can help us have potentially life-saving conversations"

DEEPIKA PADUKONE



LIFE INTER-RUPTED

Understanding India's Suicide Crisis

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UNDERSTANDING INDIA'S SUICIDE CRISIS

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INTRODUCTION

Why do we need to talk about suicide and suicide prevention in India? The short answer is that it can be the first step to saving lives. India sees approximately 20% of the world's suicides[1]—it's the number one cause of death for young Indians aged 15-39[2]—even judging by the figures we get from the National Crime Records Bureau (NCRB), which are widely estimated to be much lower than the reality.

And yet, there is an overwhelming silence around the subject, broken only by often-cacophonous news reports when there's a tragedy around a celebrity, or daily mini-tragedies, where editors and reporters share gruesome details with no thought to the well-known guidelines for the media which have been formulated specifically to prevent copy-cat suicides. There's hardly any recognition by organisations such as the WHO and the Samaritans in the 'mainstream' media that suicide is preventable, that even the way we talk about, report and address these issues via different stakeholder groups can save lives. As a country, we may have become numb to the tragedy, forgetting that there are individuals and families, ripped apart with each statistic that is reported (and as you'll read in the book, even those statistics seem to err on the side of under-estimates).

Our book will attempt to demystify the issue of suicide in India, while acknowledging that this is a complicated, multi-

factorial and inter-sectoral issue. We will hear from suicide survivors and suicide loss survivors—that is, families affected by suicide—who share heart-felt vulnerable moments from their own journeys. We will hear from senior editors, policy-makers, mental health experts and advocates, survivors, family members and more, as we draw on the available studies and research that all point to the fact that we can address this major issue, collectively. As you'll read through the following chapters you will realise that, while there are clear best practices and recommendations, which we should be looking to implement, there are also macro-level policy changes required. We need to think of the individual— the student, the farmer, the housewife—but also the collective, the social, the community—and address the social determinants which all too often play a role.

There is evidence-based science of suicide prevention that we will aim to make more accessible to a general audience. But we're talking to you as specialists too— as editors and reporters, policy-makers, teachers and counsellors, family members, this affects each one of us.

Our book is not intended to be prescriptive or even an encyclopedia on everything to do with suicide prevention. This is not an academic book, and while we draw on leading and latest sources and evidence, we are also deliberately eschewing jargon for a more conversational, accessible tone of voice. A note on the structure—you will read chapters in the first person, as well as chapters that rely on intensive interviews done with subject matter experts.

Events and panels on suicide prevention can take place every year, with the laudable goal of 'normalising' these

conversations, and they are often eye-opening. For example, when we asked audiences how many had *not been* affected by suicide at a 2019 event in Delhi, we found only a couple of hands raised in a crowd of more than 50 people.

The point is we will talk to you about real people and share real stories and real advice. We have split up the book by stakeholder in a way, and also wanted to provide as much information as possible for those of you, our readers, who may be distressed or may know someone who is distressed—we are following best practices, like referring you to a list of functional third-party helplines in India, which we have shared right at the beginning of this book.

This is by no means meant to be a depressing book— more a clear-eyed look at a very disturbing phenomenon, with practical next steps, as a call to action.

And one more note: We aren't immune to this. Of the three co-authors, all have had some personal connection to the issue, whether it is through one of our colleagues dying by suicide, or suicide attempts in the family; one of us has spoken about suicidal ideation and a phase in their life when everything seemed so bleak that suicide felt like a viable option, though this was adamantly not the case—their clear advice is that you speak to someone about what is bothering you.

(*Note: if you feel distressed, please stop reading at any point, and reach out for professional help)*

There are many issues when it comes to a complicated, inter-sectoral issue like this, but a few things to keep in mind at the outset—there are major gaps when it comes to data

collection and one major misconception is that suicide is only due to mental illness, which is emphatically not the case in India. The most dangerous issue is that the issue seems so complicated, that an almost-fatalistic attitude creeps in.

As we discuss some of these, through case studies and best practices, while addressing and busting common myths with multiple stakeholders, we hope that you will join us in this mission by becoming more informed, and sharing more from your own domain expertise and personal experience. The issue is critical, the science is being made more accessible every day, and the change could not come a day too soon. Let's not forget that behind each statistic is a real person, a real life, a real family.

INDIA HELPLINES*

- Aasra | 91-9820466726 | 24x7
- Government Helpline 'KIRAN' | 1800-5990019 | 24x7
- Psycho-social Helpline run by iCALL | 9152987821 | Mon - Sat, 10 am to 8 pm
- SNEHA Crisis Helpline | HYPERLINK "tel:+919833052684"98330 52684 / HYPERLINK "tel:+919167535765"91675 35765 | Mon - Sat, 10 am to 6 pm

Connecting NGO | 9922004305 / 9922001122 | Daily, 10 am to 8 pm

(*Note that these are third-party helplines)

CHAPTER ONE

UNDERSTANDING SUICIDE

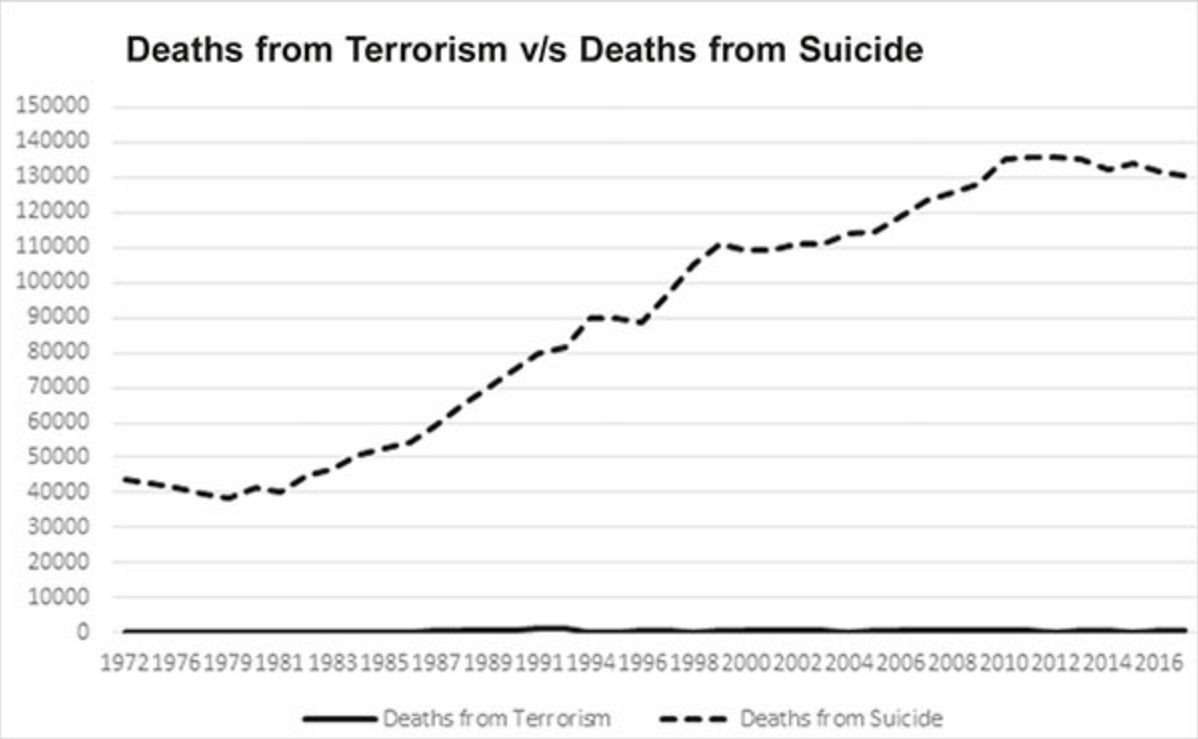
Who Is Dying of Suicide (and Why)?

In 2019, K. Sujatha Rao, the former health secretary of India, caused a minor Twitter storm with her cryptic tweet saying ‘1 needs 2 be alive 2 be a patriot’ (sic). She was referring to our political and policy priorities, which focus on issues of terrorism while neglecting the bigger killers—communicable and non-communicable diseases. When one moves the lens on to mental health to have a closer look it is clearly evident that this policy level neglect is further magnified. We got a peek into this neglect at the highest levels of government through the eyes of Ms Rao when she reminisced about her stint in the Ministry of Health and Family Welfare, Government of India. ‘I’ve worked in the Ministry of Health from 1988 onwards; from 1988 to 1993, I was director and Joint Secretary; and then from 1998 to 2003, and again from 2005 to 2010 I was Joint Secretary. In all those years, I had never heard of mental health, it was really not at all a priority or a concern for the Ministry of Health. Every Monday, we would have a meeting with the Secretary of Health… and that’s where the priority and high priority issues would be discussed. So, that I think would reflect on what really is a priority for the government at that time, and mental health was never mentioned. And so I really had no idea about mental health, I can’t even recall which

Joint Secretary dealt with it. Mental health really struck me as one of the most important areas that Ministry of Health should have been long engaged in.'

Ms Rao's assertion of misplaced priorities is certainly backed by data when we focus on suicide. The figure below compares the trend of deaths from terrorism and suicide in India over the years. Needless to say, the latter far outnumber the former. Now let us foreground that against the policy response through the most basic metric of budgetary spending. India's public health expenditure (sum of central and state spending) has remained between a meagre 1.2 per cent to 1.6 per cent of GDP between 2008–09 and 2019–20. Having established the size of the problem through broad-brush strokes, let us now try to understand some of its finer nuances.

As our society gradually becomes open to talking about suicide, the language associated with it is also becoming increasingly frequent in our regular conversations. This has invariably led to people using technical terms in an idiosyncratic manner. So, before we forge ahead, let us try to understand the concepts that we are going to come across frequently throughout the course of this book. This clarity is crucial, as vague and inconsistent use of terms and definitions will hinder our understanding of the complex phenomenon that we are trying to disentangle. Furthermore, it is important to have an accurate understanding of commonly used (and misused) terms such as 'suicidal behaviour' or 'self-harm', occurrence rates, functions, and clinical features.



Source: ADSI Reports of Previous Years. NCRB. Accessed 25 October 2021. Available from: https://ncrb.gov.in/en/adsi-reports-of-previous-years, and; Deaths from Terrorism, 1972 to 2017. Our World in Data. Accessed 25 October 2021. Available from: https://ourworldindata.org/grapher/fatalities-from-terrorism?tab=chart&country=~IND

Suicide: Death caused by self-directed injurious behaviour with an intent to die.

Suicide attempt: Non-fatal, self-directed, potentially injurious behaviour with an intent to die.

Suicidal ideation: Thinking about, considering, or planning suicide.

Non-suicidal self-injury (NSSI): Self harm performed without intent to die, usually to temporarily relieve overwhelming negative emotion, and sometimes in an effort to avoid suicidal urges

Terms such as completed suicide, failed attempt, non-fatal suicide, successful suicide, suicidal gesture, and suicide threat should be avoided as they are pejorative, misleading, and promote stigma.

The term ‘committed suicide’ conveys shame and implies that the person who died perpetrated a crime. A better and more acceptable phrase to use is ‘died by suicide’, as it is an outcome of an underlying internal or external condition(s).

Suicide and the World[1]

A question about the commonest causes of death evokes responses such as HIV-AIDS or ‘heart attack’. The former is an example of a disease that we ‘catch’ because of a bug and the latter is something we commonly get because of our modern lifestyle. Suicide is not the first (or even the tenth) cause that comes to people’s mind. This is surprising considering that it is among the top twenty leading causes of death worldwide. In fact, it causes more deaths than other health conditions that we worry about such as malaria, HIV/AIDS, and breast cancer. And, it certainly causes more deaths every year than issues that generally dominate news coverage, such as war and homicide. Putting it starkly in numbers, worldwide, approximately 800,000 people die by suicide every year. That is more than the population of Iceland, Bhutan or the Maldives! And when one considers the ripple effect of the suicide on other people, the already high numbers become mind-boggling.

There would be none better than Dr Shekhar Saxena, Professor of the Practice of Global Mental Health at the Department of Global Health and Population at the Harvard

T.H. Chan School of Public Health, to shed more light on the enormity of the challenge. Having served as the Director of the Department of Mental Health and Substance Abuse at the World Health Organisation, he has a bird's eye perspective of the issue and he says, 'For each death by suicide, there are 20 who attempt suicide. For each person dying of suicide or attempting suicide, there are at least 20 people who are affected; these could be family members, could be colleagues of friends. So we're talking about hundreds of millions of people who are affected by suicide in one way or the other. This is indeed a huge public health issue.'

Scratch under the surface of these mind-boggling numbers and what we find is a complex picture with variations influenced by individual characteristics (e.g., gender, age) and broader contexts, such as where people live. Overall suicide rates are 1.8 times higher in men than in women. Only in a handful of countries do we find suicide rates which are higher in women than in men—namely, Bangladesh, China, Lesotho, Morocco, and Myanmar. In most of the developing world, however, the ratio is almost equal. On the other hand, in the socioeconomically richer countries of Europe and North America this ratio is nearly 3:1, i.e., three men die by suicide for every woman dying of suicide. So, quite clearly this difference is not driven solely by gender but also influenced by the macroeconomic context.

Alarmingly, 79% of overall deaths by suicide, and 90% of deaths due to suicide in adolescents occur in the developing world. After road injury, suicide is the second leading cause of death in 15–29-year-olds and third leading cause of death

in 15–19-year-olds. Among 15–19-year-old girls, it is the second leading cause of death after maternal conditions and the third leading cause of death among 15–19-year-old boys after road injury and interpersonal violence.

About 10 out of 100,000 people across the world die of suicide each year. However, this number varies between countries, from less than five to more than 30. Suicide rates in Africa, Europe, and South East Asia are higher than the global average, and the lowest suicide rates are in the Eastern Mediterranean region. Furthermore, suicide is one of the top ten causes of death in eastern Europe, high income Asia Pacific, Australasia, central Europe, and in high income North America. A closer look uncovers considerable variation beneath these regional patterns. For example, the rate of suicide in South Korea in high income Asia Pacific, Indonesia in South East Asia, and Lesotho and Zimbabwe in Africa are higher than other countries in those regions and thus strongly influence the regional averages.

Just as there are geographical variations, a closer look at time trends also demonstrate complex variations. In the period between 1990 and 2016, the mortality rate from suicide increased in some countries, with the largest increases occurring in countries such as Zimbabwe, Jamaica, Paraguay, Zambia, and Belize. But the picture is not bleak across the entire world. In that same period, there have been significant reductions in mortality rates in several countries—the largest reductions occurring in China, Denmark, Philippines, Singapore, Switzerland, Maldives, and Seychelles. Finally, despite the significant reduction in

mortality rates in China, deaths from suicide in China and India together constitute 44% of global suicide deaths.

In summary, these patterns indicate that when it comes to suicide across the globe there is a complex interplay of factors, across time and geography. These include some that we have highlighted above (e.g., sociodemographic and sociocultural factors, levels of economic development), and others (e.g., unemployment, exposure to violence or use of alcohol and drugs, access to means of suicide, and patterns of mental illness) that we will tackle here and later in this book. Hence, treating it purely as a mental health issue would be missing the proverbial forest for the trees. The reality is that suicide is a multidimensional issue with complex interactions between a range of social, cultural, psychological, and biological domains.

India and Suicide

Can we trust the data?

Usually, unnatural deaths in India are reported to the police. The police investigate the death and based on the evidence collected, and sometimes the autopsy report, they put together a First Information Report (FIR), which states the apparent cause of death. These FIRs are provided to the National Crime Records Bureau (NCRB), which has been publishing annual reports on suicides since 1967. The NCRB’s reports show an increased suicide rate per 100,000 of the total population from 6.3 in 1978 to 8.9 in 1990, rising between 2006 and 2011, to 11.25, finally stabilising around

10 between 2015 and 2019, and then rising back up to 11.3 in 2020.

Although the NCRB records are the 'best' national level data that we have for suicide, they are beset by several problems. First and foremost, they are dependent on community reports and civil registration systems, and the former can be unreliable and latter inefficient. This is further complicated by the under-reporting of suicide due to accompanying legal consequences and social stigma. Until recently, attempting suicide was a criminal offence in India. The archaic Section 309 of the Indian Penal Code (IPC) clearly states that any suicide attempt shall be punished with simple imprisonment for up to a year or with fine or both. The fear of punitive action and added hassle of having to deal with police and courts often results in refusal to seek help, which in turn means that the recorded numbers are not a reflection of the truth. There has been an attempt at the decriminalisation of suicide (more details in Chapter 8) through the Mental Healthcare Act (2017) which presumes that the individual who attempted suicide to be suffering from a mental illness unless proven otherwise and seeks to provide them with care, instead of subjecting them to criminal prosecution. Despite this attempt at decriminalisation, the social stigma associated with suicide results in the NCRB grossly under-reporting the true numbers of suicide. Some of the anticipated social consequences that lead to under-reporting include difficulty in getting married and ostracization of the individual and their family.[2]

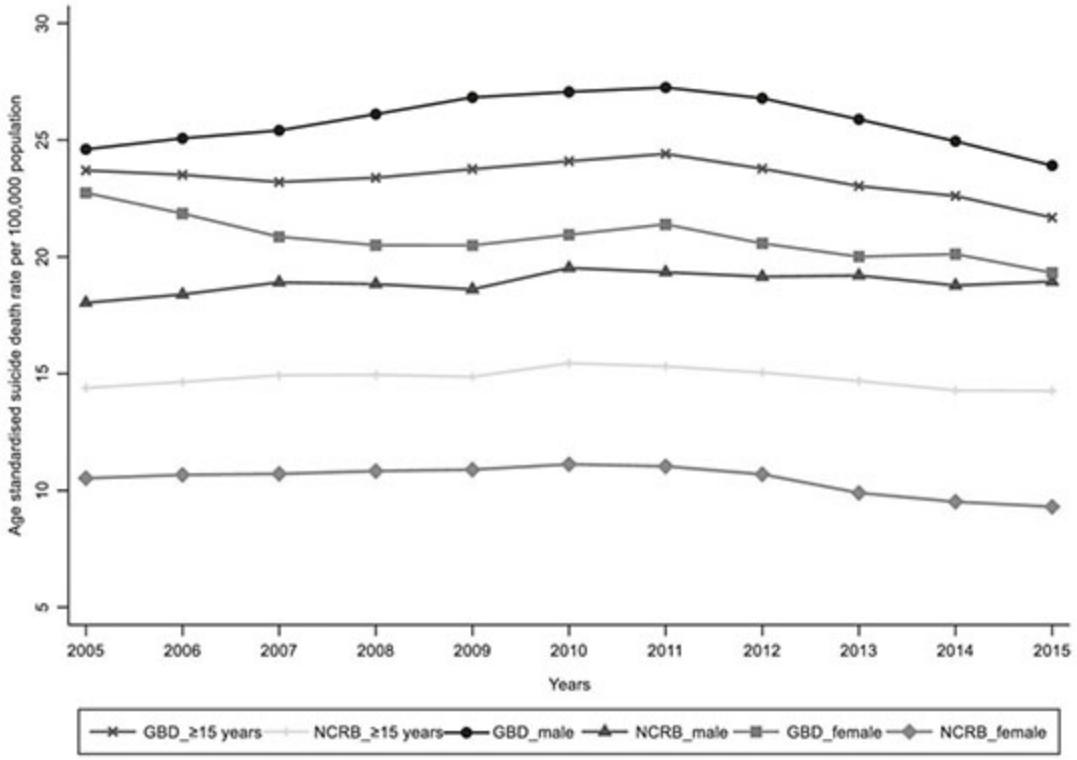
Source: ADSI Reports of Previous Years. NCRB. Accessed 25 October 2021. Available from: https://ncrb.gov.in/en/adsi-reports-of-previous-years.

On an average, the overall suicide death rate in India reported by the NCRB was 37% lower per year compared with the rates reported by Global Burden of Disease (GBD).[3] This simply means that for every 100 deaths by suicide in India only 63 get reported through the NCRB. Among men, the average under-reporting was 27% per year, and among women, the average under-reporting was as high as 50% per year. As always, P. Sainath, Ramon Magsaysay Award winning journalist who has written extensively on structural inequities in our society, pulls no punches when he addresses this issue of under-reporting. For him, it is a simple matter of wrongly registering suicide data to hide it. He says, 'Essentially, what the NCRB are having to do is to find different places to park the corpses. And you know, anyone

who works with data knows that the ultimate burial ground is a column called Others.’

The figure below is a stark representation of how the NCRB numbers are grossly lower than the GBD numbers.

Age standardized suicide death rate per 100,000 population



Source: Vikas Arya et al. J Epidemiol Community Health 2021; 75:550-555.

Despite the under-reporting, and the limitations of research studies of suicide in India, the available data offers several insights into the nature and magnitude of the

problem in India. In the subsequent sections we will try to understand some of this evidence, but always keeping in mind that it is not without its limitations. We will use two studies, one a global initiative and the other a national effort, as case-studies to examine some of the nuances of suicide in India.

The Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) 2016, is an important global initiative that estimated the burden of diseases, injuries and risk factors using data from multiple sources. As a part of that initiative, the India State-Level Disease Burden Initiative examined the trends of diseases, injuries, and risk factors from 1990 to 2016 for every state of India.

The evocatively named Million Death Study (MDS)[4] from India is one of the largest studies of premature mortality in the world. Like most low- and middle-income countries, the majority of deaths in India occur without medical attention and at home; and hence these deaths do not have a certified cause. To overcome this major gap in understanding of causes of death in India, the Registrar General of India launched the MDS which monitored 14 million people in 2.4 million households between 1998–2014. Any deaths that occurred in these households were assigned a probable cause, as determined by a method called verbal autopsy—a structured investigation of events prior to the death. Data from the MDS was used to calculate total deaths by suicide nationally and by state totals of suicide deaths; and also to understand variation by age and risks. This was the first ever nationally representative survey of causes of deaths which examined suicide as a cause of avoidable deaths in

India. These numbers are broadly consistent with those reported in smaller studies from India, but much higher than the official National Crime Records Bureau (NCRB)—the NCRB numbers being an under-estimate by 25% among men and by 36% among women.

How Many People are Dying of Suicide in India?[5]

Suicide deaths in India increased by a staggering 40% from 1990 to 2016. In 1990, India had 16·4% of the global population, but accounted for 25.3% of global suicide deaths among women and 18.7% of the global suicide deaths among men. In 2016, while India's contribution to the global population had increased to 17.8%, its contribution to suicides jumped considerably to 36.6% and 24.3% of the global suicide deaths among women and men, respectively. Thus, although the contribution of India to the global suicide deaths has increased for both sexes, the increase has been greater for women than for men.

Suicide was the ninth leading cause of death in India in 2016. The suicide rate was 17.9 per 100 000 population, accounting for 2.35% of all deaths. The suicide rate in women (14.7 per 100 000) in India in 2016 was 2.1 times higher than the global average. On the other hand, in men, the suicide rate (21.2 per 100 000 men) in 2016 was 1.4 times higher in India than the global average.

According to MDS, one out of 77 Indians above the age of 15 years is at a risk of dying of suicide by the age of 80 years. The risk is higher in men (one out of 59) than women

(one out of 100), and especially high in South India (one out of 29 men and one out of 56 women) compared to other parts of India.

The table below shows how these numbers stack up against those from developed countries.

Risk of Suicide

India (2010)	*Men*	*Women*
	One out of 59	One out of 100
US (2004–07)	One out of 63	One out of 200
Canada (2004–07)	One out of 83	One out of 250
UK (2004–07)	One out of 200	One out of 500

Are There Any Variations between the States?

These national level estimates mask the remarkable variations seen in suicide deaths at the state level. The suicide rates ranged ten-fold in women and six-fold in men between the states of India. The suicide rates in men ranged six-fold between the states of India. However, overall, suicides accounted for a lower proportion of deaths in the relatively less developed states than in more developed ones. The possible explanations for these differences may lie in variations in suicide registrations but also in the huge inter-state variations of factors that are associated with suicide

such as agricultural employment, unemployment and literacy rates, and religious and ethnic distribution.

Suicides are about two-fold higher in rural than in urban areas; and there are great variations in suicide rates between individual states (6.3 to 66.3 per 100,000 for men, 2.2 to 39.7 per 100,000 for women). A disproportionately high 42% of suicides in men and 40% of suicides in women occur in the four southern states of Andhra Pradesh, Karnataka, Kerala, and Tamil Nadu which together constitute 22% of India's population. They are followed by Maharashtra and West Bengal which together account for an additional 15% of suicide deaths.

The MDS confirmed the most counter-intuitive trend observed in the NCRB data for several years—nearly a tenfold higher suicide death rate in the southern states compared to the northern states, even after accounting for the differences between these two regions such as education and religion. Although we do not have sufficient empirical data to make a definitive conclusion, this finding is consistent with observations in other parts of the world that increasing modernisation is associated with high suicide rates, while traditional societies have lower suicide rates.[6] The south Indian states have greater literacy rates, urbanisation rates, per capita income, and life expectancy rates as compared to north India, and are experiencing more rapid modernisation and social change. One could speculate that this ecological reality coupled with an increasing gap between expectations and reality, and the social acceptance of suicide as a legitimate solution to unfavourable circumstances results in the greater burden of suicide in these states. Finally, we

would like to temper these observations connecting better socioeconomic indicators with higher suicide rates by looking at the state of Chhattisgarh which bucks the trend. Home to 26 million people, Chhattisgarh has one of the highest poverty rates in the country. Over the years it has also consistently been one of the top five states for suicide rates, often ahead of some of the more developed states from southern India.

Does Gender Matter?

India's men-to-women ratio for suicide rates was lower than the global ratio in 2016, i.e., the gap in suicide rates between men and women in India is smaller than in the rest of the world. Some of the proposed factors that could account for the gender differential include differences between the two sexes in socially acceptable methods of dealing with stress and conflict, availability of and the preference for different means of suicide, differences in alcohol consumption patterns, domestic violence, and differences in help-seeking for mental disorders. Additionally, there is the differentially increased risk afforded to married women compared to men because of early marriage and motherhood, lack of autonomy in choosing partner, domestic violence, and economic dependence on the husband.

On an average, the men-to-women suicide death ratios in high income countries is approximately 3 to 1, i.e., for every woman that dies by suicide there will be three men who die by suicide.[7] This is not so in India where the male-to-female suicide death ratio is about 1.5 to 1 at all ages (for every

three men who die by suicide, two women die by suicide), and this gap is further reduced among young adults. Finally, the suicide rate among Indian women is more than two times greater than women in high-income countries and although it is higher among Indian men compared to men in high-income countries, the gap is to a lesser extent.

Does Age Matter?

Unlike most developed nations, a double peak for suicide deaths is seen in India, with the first in younger population and the second after 70 years of age, and the peak in the younger ages is much more distinct in women than in men. The more pronounced peak among young women in India could be attributed to gender role differentiation and discrimination (e.g., early marriage), and a higher risk of depression, all of which constrain their aspirations and opportunities. On the other hand, the peak in the elderly could be attributed to social isolation, depression, functional disability, and the feeling of being a burden on their family; although we must acknowledge that not much is known about suicide in the elderly in India.

Worryingly, MDS data indicates that a large proportion of deaths by suicide are in young Indians— about 40% of male suicides and about 56% of female suicides occur at ages 15–29 years. Suicides occur at younger ages in women (mid-twenties) than in men (mid-thirties). Furthermore, male death rates are generally consistent across age groups, while in females it peaks at ages 15–29 years, and then falls for older women. Suicide is one of the leading causes of

deaths among young Indians—second only (and marginally so) to road traffic accidents in men and maternal deaths (death during pregnancy or immediately after) in women. The latter indicates that given the steady declines in maternal mortality because of improving access to perinatal care in India, suicide is set to become the leading cause of death in young women in India in the near future.

Is There Anything Else that We Should Be Aware of about Suicide in India?

The commonest method of suicide is by hanging, followed by poisoning with agricultural pesticides (chiefly organophosphates). Self-immolation accounts for about one in six suicides among women (Note: this is as per 2019 & 2020 NCRB data). The easy accessibility of agricultural pesticides (the commonest mode of suicide) combined with the poorer access to emergency medical care in rural settings could possibly explain the higher rates of suicide in rural compared to urban India.

The risk of dying by suicide is greater in those with a higher education level. Especially among men, alcohol consumption, being a cultivator, and rural residence, are all associated with a greater risk of dying by suicide. Among women, being widowed, divorced or separated, is associated with a slightly reduced risk compared to those who are married.

These numbers are just a few pieces of a complex jigsaw puzzle. There are many pieces that are still missing. There are several reasons for this, such as lack of credible data

and robust systems to collect such data, and the disinterest of policymakers in understanding suicide beyond the narrow prism of mental ill-health or the more politically charged farmer-distress.

Professor Shekhar Saxena says, ‘Suicide is an issue for the entire community. And in fact, for governance, policy and even politics, because in many countries it does come up as a political issue from time to time. And in India, it has come up in a big way, as we know, in the last 15 years, much more for the last five years. In terms of student suicide, farmer suicide and young people’s suicide. Suicide also comes in public and policy discussions, its relation with the other social factors, including extreme poverty, urbanization, joblessness, dowry, deathss and harassment of women, violence against women. There are these and a number of other social factors, which are interacting with suicide all over the world, but much more in India.’ Hence, the first step towards identifying some of the missing pieces of the jigsaw puzzle is to attempt a more rounded and contextual understanding of the social drivers underpinning this phenomenon and commitment from various stakeholders to address these drivers. In the absence of a holistic understanding of such drivers and consolidated efforts to address them we run the risk of continuing to run in circles with no end in sight to the problem.

CHAPTER TWO

NOT TOO YOUNG TO DIE

The National Crime Records Bureau (NCRB) of India released the suicide statistics for 2020 just before Diwali 2021. While you continue reading, do remember that NCRB data consistently under-reports the real number of suicides, so things may be worse than they appear to be now. NCRB reports the suicide rate, i.e., number of suicides per 100,000 population, went up from 10.4 in 2019 to 11.3 in 2020, a 9 per cent increase. However, as India's population continues to grow each year, the absolute number of suicides went up from 139,123 suicides in 2019 to 153,052, a 10 per cent increase in 2020.[1]

This number, while bad enough, does not tell the entire story, especially when it comes to young people. Suicides amongst children under 18 years rose from 9,613 in 2019 to 11,396 in 2020, an 18.5 per cent increase, nearly double that of the increase in the total population. This is a significant spike in suicides in young people. If you compare the data for the last five years, children's suicides increased by 4 per cent in 2017 compared to the previous year, by 1 per cent in 2018, by 2 per cent in 2019 and then this huge spike of 18.5 per cent in 2020.

Why did we see this huge increase in a pandemic year when lockdowns meant that families were at home with children? We can only speculate. Unfortunately, the NCRB does not release raw suicide data so we cannot explore the

data further. This is yet another reason why NCRB should release the primary data; to allow for better exploration of the factors leading to children's suicides. The Registrar General of India releases the raw Census data, allowing health and social researchers to analyse it and draw useful conclusions. There is little reason why the NCRB does not do the same with the suicide data. The NCRB itself does not do any detailed analysis of the suicide data. We release the Census data, so what's the harm in releasing suicide data?

Girls below 18 years are particularly vulnerable and dying in greater numbers than boys. While the gender ratio for overall suicides is 2.4 (two and half times more men than women dying by suicide), the gender ratio for children under 18 years is 0.9 (9 boys dying by suicide compared to 10 girls). These ratios are not a one-off unusual feature for 2020 but have been stable over many years.

The impact of the pandemic, when schools and colleges were closed and examinations deferred by most universities and state governments, is significant—suicides due to 'failure in examinations' actually fell to 1,129 in 2020 from 1,577 in 2019, a *reduction* of 28 per cent.

For the age group from 18 to 30 years, suicides rose from 48,774 in 2019 to 52,718 in 2020, an 8 per cent increase, slightly less than the overall population increase. If you compare the data for the last five years, young people's suicides increased by 5 per cent in 2017 compared to the previous year, by 4 per cent in 2018, by 4 per cent in 2019 and a significant uptick of 8 per cent in 2020.

In this age group, the gender ratio is 1.9 (nearly two young men dying by suicide compared to two young women), which

is still lower than the gender ratio of overall suicides at 2.4, but higher than the gender ratio for children as show above.

In this age group too, ‘failure in examination’ as a cause for suicide fell from 1,091 in 2019 to 860 in 2020, a *reduction* of 21 per cent.

The COVID pandemic and the cancellation of examinations was a natural experiment which proved something suicide prevention researchers had suspected for a long time. In a year when suicides increased dramatically, there was an equally dramatic fall in suicides due to failure in examinations.

As Lakshmi Vijayakumar, who runs SNEHA, a suicide prevention helpline said, ‘During the results time, the 10th and the 12th exam results, we had a lot of youngsters calling, and all of them will call at 10–11 pm and so we extended our working hours. We kept the Centre open 24 hours. During the results’ time, the number of students who are calling increased three times, four times.’

India’s examination system is in the dock, as far as suicides amongst children and young people are concerned. Isn’t it time our educationists and educational authorities take a hard look at it for the sake of young people’s lives?

Tamil Nadu has made a small beginning. To quote Lakshmi Vijayakumar again, ‘Tamil Nadu was the first state to introduce the supplemental exam system, that is students who fail the Board exams can write their exams again within a month or two, so they don’t lose an academic year and they can go ahead. This was introduced in 2003. If you look at the number of suicides due to exam failure before the introduction of the supplemental exam, from 400 it has come

down to 200-230. In Chennai, it used to be 50-60 students dying because of exam failure. Now, it isn’t in double digits. Although the number of students who are writing the exams has increased many times.’

This is yet another example of how policy changes in sectors other than health have a more significant impact on suicides than interventions in the health sector alone. After reading the data above, ask yourself what the Government response to exam-related suicides in most states has been—opening helplines in June and July each year during the results season. How many states have actually taken policy steps which can bring about a significant reduction in exam failure related suicides?

If you read the narrative in our newspapers and look at the data above, you may mistakenly conclude that suicides amongst young people are largely due to the education and examination system. However, these exam failure suicides contribute only 10 per cent of the total suicides in children under 18 years and less than 2 per cent of all suicides for those under 30 years. So while education policy changes are important and will save lives, its impact on the total number of suicides in these age groups will be small or marginal at best.

What are the major drivers of suicides in these age groups? NCRB data shows ‘family problems’ are the largest contributing cause in 2020—35 per cent of suicides for under 18-year-olds were attributed to this cause, and 34 per cent of suicides for under 30-year-olds were attributed to this cause. Unfortunately, the NCRB data does not give any

indication what these ‘family problems’ are which lead to suicides.

Another important problem with the NCRB data is that every suicide is attributed to a single cause. This is a very simplistic understanding of suicides, as research has shown that suicides are multi-factorial in nature. Most suicides are due to a combination of factors in a vulnerable individual at a vulnerable time in their life. This is particularly true about children and young people. It is quite likely for example that a young person already has family problems and an exam failure precipitates a suicide. We still do not know how the NCRB makes the decision to put such a suicide into either the family problems category or the exam failure category.

However, be that as it may, the data highlights that we need different interventions for different problems even within the same age groups. This is further complicated by other inter-sectional issues—caste, religion, gender, income and social class, to name just a few.

If we examine the categories used by NCRB as causes of suicide, one realizes how little thought has gone into this classification. For example, ‘family problems’ are a separate category while ‘marriage-related problems’ are another separate category and ‘love affairs’ (sic) are another. How a particular suicide is allocated to any of these categories is not known. Who makes this judgement and on what basis is this judgement made, to assign a particular suicide to one of these categories?

Almost 25-30 per cent of suicides in NCRB data for children and those under 30 years is allocated to ‘Cause not

known' or 'Other causes' (NCRB does not give any details of what these other causes include).

Data from across the world shows that childhood experience of abuse (physical, sexual, emotional) is significantly associated with suicides and suicide attempts in adolescents and young people. However, the NCRB data has a single category of 'Physical Abuse (Rape etc)' (sic) and barely 41 of the nearly 55,000 suicides amongst those below 30 years is attributed to this cause.

There are significant gender differences in young people's suicides. Based on Global Burden of Disease data, Dandona and colleagues reported that in 2016, young women below 39 years accounted for 72 per cent of all women's suicides, while it was 57 per cent for men.[2] Suicide was the number one cause of death for young women aged between 15 to 39 years while it was the number two cause of death for young men aged between 15 to 39 years.

The 2020 NCRB data shows similar trends. Young women below 30 years of age accounted for 24,707 of the total 44,498 women's suicides, which is 55.5 per cent; while for young men below 30 years the corresponding numbers are 40,021 of 108,532 total men's suicides, which is 36.8 per cent.

Suicides are therefore a significant cause of death, most likely the number one cause of death for young women in India. Why is this so? We don't really have good data to draw firm conclusions from, but suicide researchers like Lakshmi Vijayakumar draw attention to domestic violence and patriarchal family setups leading to increased stress and vulnerability to suicides for young women.

So what should we do going forward?

Repeatedly, what comes up is the lack of good quality data. Despite suicides being a significant public health concern, India's health policy-makers have not invested in collecting detailed data. Data can not only give us a better understanding of the factors leading to young people's suicides, but also help design suicide prevention strategies targeted at specific sub-groups such as young women, men, and farmers, for example.

The NCRB (the only national agency which collects suicide data in India) releases an annual report on suicides. This report provides some details about suicides such as gender, age, occupation and some simple tabulations of the interaction of a few factors—for example, age and gender by state. These limited analyses do not provide information for researchers and public policy planners to design suicide prevention interventions. The NCRB, for reasons best known to them, do not release the primary data which could allow researchers to do a detailed analysis of the suicide data. The data collected by the NCRB is also limited to few demographic indicators and the quality of data is also poor, as shown by many studies.[3]

The NCRB is a police agency and it's a historic anomaly that suicide data is collected by this agency. It is time that the government entrusts the task of suicide data collection to a public health agency to allow for better data collection. This is the practice in most countries and we need to urgently move to a public health model of suicide prevention, starting with data collection.

At present, neither NCRB nor any other government agency collects data on suicide attempts. A previous suicide attempt is one of the best predictors of a future suicide and hence it provides opportunities for early intervention and suicide prevention. It is, therefore, imperative that a public health agency collect not just suicide data, but also data on suicide attempts and this should be done immediately.

We already have clues to successful youth suicide prevention from data and research from other countries. Gatekeepers are important people in the community who are strategically placed to identify people at risk for suicide. With respect to young people, school and university teachers are important gate-keepers and gatekeeper trainings are incorporated in teacher training programs in many countries. It also highlights the need to work across sectors for suicide prevention. While suicides and attempted suicides are a public health problem, effective interventions may lie outside the health sector, for example in the education sector. Will such interventions work in India to prevent suicides in young people? We do not know, and we will not know until we invest in public health research to answer this question. We need research to not only answer the effectiveness question (will gate-keeper training work?) but also to identify the specific challenges in scaling up a gatekeeper training program across the country.

There are other equally effective programs for youth suicide prevention in other countries. The SEYLE project across 10 countries in Europe tested three suicide prevention interventions in nearly 11,000 adolescents.[4] It included a gatekeeper training program, a five-hour mental

health awareness training designed to promote knowledge of mental health, healthy lifestyles and behaviours among adolescents and a third intervention namely, screening of at-risk adolescents by health professionals. The study showed the five-hour awareness training (called Youth Aware of Mental Health or YAM) was effective in reducing suicide attempts as well as severe suicidal ideation in adolescents at 12 months follow up. Such interventions are particularly relevant for India—they are low-cost, do not require highly skilled mental health professionals and can be delivered in the classroom—as they can be quickly scaled up across the country. However, we need research in India to test whether such interventions which work in Europe will work in India and what adaptations may be necessary for these interventions to work in Indian school settings.

India has hardly invested any resources in suicide prevention research, despite suicides and attempted suicides being a big public health crisis for many years. One possible reason for this lack of research investment is because suicides are not seen as a public health issue and none of the existing public health agencies have suicide prevention as one of their health priority areas. It is time for India's health policy-makers and planners to consider setting up a specialist public health agency (as we did for HIV/AIDS) for suicide prevention. This agency can collect suicide data and statistics, invest in suicide prevention research, and establish and expand suicide prevention programs across the country.

India is a young country and 50 per cent of India's population is under 25 years of age. India's politicians and policy-makers frequently talk of India's so called

‘demographic dividend’—our potential economic growth from having a young population. Unfortunately, as things stand currently, India’s demographic dividend is killing itself. And we do nothing about it.

CHAPTER THREE

FINAL INNINGS

Suicide and the Elderly

- ‘Elderly man commits suicide by jumping into lake in Thane’
- ‘Elderly man dies by suicide in Sector 24, leaves behind note’
- ‘75-year-old commits suicide inside mosque in Bihar’
- ‘94-year-old woman jumps to death from 15th floor in Gurugram’
- ‘Abandoned’ elderly couple commits suicide’
- ‘Elderly man hangs himself to death’
- ‘Retired IFS officer shoots himself dead at his house in Delhi’s Defence Colony’
- ‘Pune: Elderly man commits suicide due to fear of COVID-19’

These are all recent headlines from Indian newspapers. Pithy headlines, but enough to make one pause for thought. As you will note in our chapter on the Media (Chapter 8), these headlines definitely do not follow best practices of reporting suicide. But let us come to that later.

For the moment, let us focus only on the content of the headlines. Even without additional context they are sufficient to indicate that something is just not right here. They also highlight some key differences from suicide in young people (See Chapter 2). This chapter should help shed some light on those differences.

The elderly are supposed to die peacefully in their sleep. At worst, they are supposed to die of long-standing illnesses. They are not supposed to kill themselves in the sunset of their lives. What is it that prompts such an action when one would expect them to have endured and worked past any difficulties that life has thrown at them over several long years?

As we try to unpick some of these complex issues and start to understand this phenomenon, let us look at it through the cold statistical lens. It is important to do that as a lot of our subsequent story rests on the demographic argument.

Contemporary India is a young nation. In fact, it has one of the youngest populations in the world. However, that is not going to last for long as demographic ageing is one of the inevitabilities of nature. So, in India, the number of older persons is projected to grow by 64% between 2015 and 2030. (Older person here is defined as anyone above 60 years of age.) The percentage share of our population over the age of 60 is expected to increase massively; from 8% in 2015 to 19% in 2050. For a nation, where a fifth of the population is going to be made up of older adults in the near future, it is imperative that we start thinking about the issues that accompany the ageing process. Indians are living longer. Our life expectancy has increased from 56 to 71 years

between the early 1970s and now. Although that is unquestionably good news, is our society equipped to take care of those living longer? The answer is a resounding no!

And it's not just India that is dealing with this phenomenon.

In 2017, the Senate Aging Committee in the USA held hearings to examine the mental and physical effects of social isolation and loneliness. In 2018, Theresa May, the then Prime Minister of the United Kingdom, appointed a 'Minister of Loneliness' to tackle the social and health issues caused by social isolation. Following the UK, Japan appointed a Minister of Loneliness, specifically to tackle suicide rates, according to news reports. While developed countries have started to take this matter seriously, the developing world is yet to fully wake up to this reality of modern life.

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In a country of 1.3 billion (and growing), one can never be 'alone'. But 'loneliness' is a different ball game altogether. And there are examples of the latter all around us. Earlier, say, in a typical Bombay colony of two apartment blocks within a small walled compound, everyone knew everyone else. Young families, lots of children, and a constant bustle defined life in the colony. The day typically ended with kids playing gully cricket in the compound, teenagers lounging around shooting the breeze, and the adults getting together for their daily dose of gossip.

Cut to 2020. There is nothing to indicate this was once a bustling colony. The children have grown up and moved along; migrated out of the city or to the West. What is left behind is memories, and elderly parents. Recently, in a

neighbouring building, an elderly lady living by herself died while watching TV. Her body was discovered only a few days later, after the maid raised an alarm as she was not opening the door of the apartment to let her in.

This is the story of urban India. As young adults migrate to greener pastures across the country and overseas, the number of elderly living by themselves is increasing. Rural India is not far behind as well. Dwindling employment opportunities results in rural to urban migration of young people, and there is no role for the elderly in this new reality of India. But this is only one aspect of the larger picture.

A common thread that runs across the stories of many older adults are the problems that commonly accompany ageing. Chronic physical health problems, loneliness, caregiving responsibilities, reduced income, dwindling social networks, and abuse, are an everyday part of life for many older adults. Many of these remain hidden behind the four walls of people's houses but it is not difficult to see how these, independently or cumulatively, will lead to situations of stress and suicide. So, let us look at some of these issues through the various facets of Ratnakar's life and try to disentangle the complex mechanisms through which they work. Although the names and locations of the protagonists have been changed to safeguard their confidentiality, Ratnakar's story is a composite of stories of real people that I know.

Ratnakar is a 70-year-old pensioner, living in Udupi with his 65-year-old wife, Renuka. All his daughters are married and settled in distant towns, one each in Vengurla, Sri Ganganagar and Gwalior. His only son lives and works as an

accountant at a small firm in Bengaluru. His wife has been chronically unwell and in recent years, she has been bed-ridden with Ratnakar as the sole caregiver. Ratnakar himself has been diagnosed with arthritis that gives him pain and restricts his mobility. Despite that, he is searching for a suitable job so he has enough money to supplement his meagre pension and meet his daily expenses. He is spending a major chunk of his pension on medicines for his wife.

One of the inevitable outcomes of ageing is the increasing prevalence of chronic diseases. These commonly include conditions such as arthritis, heart disease, stroke, cancer, and diabetes. These are 'costly' health conditions, and negatively affect quality of life by contributing to decline in functioning and community participation. A staggeringly high two out of every three elderly individuals in India have some chronic disease, according to the recent and first Longitudinal Ageing Study in India (LASI) (2020).[1] Almost a quarter of this population have more than one chronic disease.

Chronic physical illnesses are common in the elderly and contribute to the risk of suicide. No specific physical illness is directly linked to the risk of suicide but the risk builds cumulatively through the number of physical health conditions. For example, compared to an elderly person with no physical illness, those with three illnesses have a threefold increase in risk and those with seven or more illnesses have a nine times greater risk for suicide.[2] Thus, the higher the number of physical illnesses, the greater the risk of suicide in the elderly.

A much more nuanced exploration of this phenomenon indicates that it is not the mere presence of a physical illness, but the perceived meaning of the illness, its impact on functioning, association with pain, and threats to personal autonomy that play key roles in the pathway that leads from the physical illness to suicide. The presence of one or more chronic illnesses in older adults does not just have implications for physical wellness but also intersects adversely with several other domains of the person's life, all of which in turn could increase the risk of suicide. These include untreated or poorly controlled physical pain associated with many physical health conditions, impaired functioning, threats to autonomy, financial burden of healthcare including cost of medications, reduced mobility and consequent dwindling social networks, worry about the progression of the medical illness, and fear of becoming dependent on and burdening the family, all of which can have an effect on mental health and overall quality of life of the older adult. Thus, although physical illness plays an important role in the suicidal behaviour which occurs in late-life, it is unclear if it is an independent risk factor, outside of the context of a mental health problem, such as depression.

Despite India's recent rapid economic growth, the living conditions of a majority of older Indians remain sub-optimal. Very few older Indians have the safety net of state-sponsored social security. There is no pension of any sort, and many do not have adequate savings because their earnings were low through their life. Consequently, many older adults are highly dependent on family support to manage their standard of living in old age. In both urban and rural areas many elderly

people live alone or only with their spouse, and an increasingly greater proportion of older women are living alone. Additionally, they have extremely limited social interaction opportunities available due to dwindling networks and reduced mobility. Finally, one out of every 20 older adults in India experience ill-treatment (women more than men) of which one-fourth experience physical abuse and/or economic exploitation, and more than half experience neglect. Importantly, this ill-treatment is often perpetrated by the person who provides them ongoing care (e.g., their children, sons/daughters-in-law), which in turn means that the victim is less likely to report such incidents for fear of losing the care.[1]

'Connectedness' at the personal, family, and community levels is an important factor when considering elderly suicide—the greater the number of close confidantes, the lower the risk of suicide in older adults. The 'Interpersonal Theory of Suicide' helps us understand this complex relationship between 'social connectedness' and suicide.[3] This theory posits that 'suicidal desire' is caused by the simultaneous presence of 'thwarted belongingness' (I am alone) and 'perceived burdensomeness' (I am a burden). A perception of 'thwarted belongingness' develops when the lack of social connectedness results in the fundamental human psychological 'need to belong' being unmet. Perceived burdensomeness flows from two aspects of interpersonal functioning—that one is flawed and hence a liability on others (I make things worse for the people in my life) and beliefs of self-hatred (I am useless). The conditions that surround the elderly make the situation ripe for all of these

cognitions operating together to increase the ‘desire for suicide’.

The key life events that contribute to this loss of connectedness are bereavement and spousal loss, both of which are especially common in later life, and are significantly distressing events. Bereavement resulting from spousal loss in the elderly results in a reduced sense of belongingness and connectedness. This is felt most intensely in the immediate period following the loss of a spouse and might be greater in men than in women. The gender variation might be due to the differential psychosocial function of marriage based on gender and possibly the lower ability of men to maintain social ties compared with women.

Thus, one finds that following widowhood, many withdraw emotionally and socially to conserve one’s energy for personal coping and this frequently happens in parallel with decreasing social support. Social support during the grieving process can be limited because social networks of older adults keep changing, and the frequency of social participation and contact is often decreased. This occurs because poor health and reduced mobility act as barriers to social connectedness. Finally, in addition to reduced social networks, spousal loss in the elderly often happens during a life phase in which financial, cognitive and adaptive resources are also declining.

Although loneliness can become a common challenge for bereaved older adults, those who have a wider network of friends are less affected. Thus, social support, social networks, and social engagement, can benefit older adults’ well-being and facilitate their psychological adjustment to

the death of a spouse. Emotional support from children is helpful, though financial and practical support may increase stress for older men, as it implies inefficacy and violates the traditional gender role of men as breadwinners. Living with children could have beneficial implications but can also lead to greater interpersonal conflict and increased demands on older people, which can harm their mental health.

Interestingly, bereaved elderly men have lower life satisfaction than bereaved women. The decline in life satisfaction for men could be because some older men struggle to learn to manage tasks that used to be completed by their spouse. Additionally, men tend to derive more emotional support from a marriage than women, and hence are more at risk of health problems after losing a spouse due to the absence of emotional support, insufficient nutrition, and drinking and smoking habits.

Older spouses are often highly dependent on each other, as informal care provided by the spouse is very common among older adults. Older spouses often have a relationship which is built over a long time, with a long deep shared history and closely interwoven lives, often due to traditional gender role divisions and dependency on one another to help with daily tasks. Loss of these functions of the relationship add to the feelings of loneliness and helplessness. Finally, the caregiving burden prior to bereavement can lead to poorer self-care in the period leading up to spousal bereavement, which in turn leads to health decline in the surviving partner after the bereavement.

After Renuka passed away, Ratnakar found it increasingly difficult to live by himself. He no longer had anyone in his life

to share his feelings with. He began to have a lot of spare time now that he was relieved of his care-giving responsibilities, but did not have any social networks to speak of as they had constricted over the preceding years. As he is not digitally literate, he finds it difficult to interact with his children and grandchildren using modern technology.

Retirement is another major life-event in the life of older adults and has varying effects on health, depending on individual attitude toward and reason for retiring. Some may have difficulty adjusting to aspects of retirement such as reduced income and entitlements, and altered social role. While some people choose to retire, having looked forward to quitting work and hence finding it easier to adjust to. Others, who are forced to retire, might struggle to deal with the change.

Relocation may occur for some elderly. This might include shifting to retirement housing or to smaller housing to reduce the burden of upkeep, or to the homes of adult children. The less perceived control over the move and the less predictable the new environment seems, the greater the challenges in adjustment. Finally, although for some elderly people, relocation might be helpful, they continue to remain in problematic homes or neighbourhoods because of financial, social, and other compulsions.

Over time, as it becomes difficult for Ratnakar to manage by himself he is forced to leave his rented apartment to move to the city and live with his son. Life in the city is difficult for him as he is now cut off from his routines and the few social connections that he had. Stuck in a little apartment with no sense of purpose, his daughter-in-law starts mistreating him.

He finds it awkward to complain about this to his son. However, because of his limited finances and physical health problems, living independently is not a choice that he has.

Eventually, when things come to a head, Ratnakar's daughter takes him to live with her in Vengurla. However, this is a temporary arrangement. He will not be here for long and will soon move to his second daughter's house in Sri Ganganagar and then soon thereafter to his youngest daughter's house in Gwalior. This is an arrangement worked out among his daughters after his daughter-in-law asked him to leave the house. Since he has a limited income and no independent housing, he continues to remain dependent on others.

Ratnakar is not unique in India. He represents the personification of one or more of several troublesome issues that older adults in contemporary India struggle with. However, this struggle happens in the shadows as the country, enamoured with the economic potential of its burgeoning young demographics, chooses to ignore or downplay the problems that the elderly face. But there is no running away from these issues that will become increasingly common as people live longer and the law of nature ensures that the current demographic, which bulges at the younger end of the age spectrum, inevitably expands at the other end.

The age-related causal factors and potential solutions notwithstanding, what is it about suicides in the elderly that merits a separate examination? Suicides in older adults are peculiarly distinct from those in their much younger counterparts in several ways. Gender remains one such key factor. Although men complete suicide more frequently than

women in adulthood, this ratio increases dramatically with age: there is a massively increased suicide rate in elderly men but not as much in elderly women.

One of the key steps towards preventing suicide is the detection of suicidal ideation and intent in a timely manner. However, this is a particularly challenging task in the elderly for several reasons. On the one hand, older adults are less likely to directly report suicidal thoughts compared to younger adults. On the other hand, death wishes which could otherwise potentially indicate suicidal intent might be ignored as the former are quite common among the elderly and do not always indicate intent to actively end one's life. Finally, there are certain potentially life-threatening behaviours that some older adults intentionally engage in which could eventually lead to their death; but do not get labelled as such even when accompanied by the older adult's stated wish to die. Such behaviours include refusal of medication, food, or liquid, ignoring medical advice, and living in unsafe/ unsanitary conditions.

Compared to younger adults, the elderly make fewer suicide attempts but the ones that they do make are much more lethal. The choice of method for attempting suicides are those with more inherent lethality, such as hanging or drowning. Thus, suicide attempts by the elderly are more likely to lead to completed suicide than in younger age groups and this is especially true for older men. Additionally, suicide attempts in the elderly are less impulsive as compared to younger individuals. For example, the elderly are less likely to be intoxicated while carrying out the attempt than younger attempters. Overall, suicide attempts

by the elderly are characterised by greater seriousness of intent, higher degree of premeditation, and higher lethality, decreasing the likelihood of being rescued.

All of this brings me back to my experiences of visiting my aunt in Mumbai. Her housing colony as it used to be, and how it is now. Knowing what we know, given the startling story of the elderly neighbour dying and not being discovered for days, and with the knowledge of the inevitable demographic ageing and outward migration in a developing society, what is it that we can do differently?

And, what is it that our elderly protagonist Ratnakar seeks? Seemingly, not much. What he needs is some sort of social security in the form of people and money which would reduce his physical and psychological burden as the sole caregiver for his wife, and ease the financial drain resulting from healthcare expenses. What he needs is some consistent social interaction and a system that robustly secures his rights and protects him from abuse. What he needs is secure and safe supported housing where he can live with dignity. Most importantly, he needs autonomy and choice—the option to live his life the way he wants.

Much of this can be achieved at no great cost by facilitating an inclusive environment which is more age-friendly and allows the elderly to actively participate in community activities, respects their decisions and lifestyle choices, makes it easy for them to stay connected with people who are important to them, supports them in staying healthy and active, and provides appropriate support to those who can no longer look after themselves. This involves investing in and enabling systems such as accessible

transportation, barrier-free spaces for active leisure and socialisation, social support and outreach, accessible healthcare, appropriate, affordable and safe housing, services to assist with household chores, caregiver supports, and safety from abuse and victimisation.

When it comes to the care of the elderly, India has a lot to learn from other countries. In 2018, the Research Network on an Aging Society ranked several countries on the Aging Society Index which rates on different dimensions such as 'productivity and engagement' (e.g., opportunities for elderly people to contribute to society), 'well-being' (e.g., life expectancy and life satisfaction), 'equality' (e.g., poverty risk for the elderly, food security for the elderly), 'cohesion' (e.g., how socially supported elderly people are), and 'security' (e.g., income, physical safety).[4] Not surprisingly, the Scandinavian countries of Norway and Sweden topped the charts. So what is it that these Nordic countries are doing better than other parts of the world? For starters, most older adults in these countries continue to live in the same home that they lived in during their working lives, and only when this is no longer possible, they move to special accommodation adapted to the level of their needs. The goal is to ensure that these older adults are able to live in their own homes for as long as possible, sometimes through the support of home-care services which are funded by the local government. Various types of aids are provided to help people remain in their own homes and to make their life easier, e.g., security alarms. Finally, people under a particular financial threshold are provided financial support in addition to the social insurance system to cover living

expenses. The aim of these measures, usually mandated by a range of legislations, is to ensure that older adults are enabled to lead an active life, exert autonomy over their everyday lives, age safely and in a dignified manner, and have access to good care and treatment.

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All of these measures might not be within India's reach presently. However, what is important to remember is that ageing is a lifelong process and such an age-friendly approach is a strategic investment which will not just benefit the elderly but all age groups. In such an age-friendly society, the vision is of a Ratnakar, living independently in his own home, with support from family as well as health and social service providers, digitally connected to family and relatives who might be living at a fair distance, attending community events, feeling included in his community, and feeling respected, valued and safe in his environment.

We expect such universal measures to go a long way in alleviating the upstream drivers that lead to suicide in the elderly. This would also need supplementing with initiatives that tackle those who are at a higher risk of suicide or actively contemplating suicide. In addition to the more generic suicide prevention methods that apply across all age groups and are deliberated on in more detail in Chapter 10, we also need to focus on some specific interventions that are responsive to certain idiosyncrasies that are peculiar to suicide in this age group.

Despite the high risk of suicide in the elderly there is a shocking paucity of research on interventions designed to

prevent suicide in this population group. However, the available preliminary evidence does give some pointers on what could possibly work. One key strategy is increasing awareness about elderly suicide amongst the general public, and more specifically among a range of organisational and community gatekeepers (e.g., bank tellers, pharmacists, clergy) who regularly come into contact with older adults through the course of their work. This involves not just awareness of mental health problems in the elderly but also about losses that might be a part of life but are important to older adults, such as retirement and loss of important body functions.

Because of the close association between depression and suicide, the detection and effective treatment of depression in the elderly is a key strategy. This involves training professionals to detect, intervene, and manage depression and consequent suicide risk. This might mean exploring painful chronic physical conditions or sleep disorders as an entry point to initiate an assessment as the elderly might find it easier to talk about those than emotional distress with their healthcare providers. Practice guidelines deployed in healthcare and social care settings should encourage use of routine screening tools for detection of depression and use of counselling (such as problem solving therapy or interpersonal therapy) and antidepressant treatments as appropriate.

All opportunities (home visits, case management, nursing care, follow-up, contacts with caregivers), both in person or digital, must be used as an opportunity to develop a confiding relationship with a helping person. Such contacts should also

be used strategically to monitor high-risk individuals, offer support to address sources of distress, and reassurance of at-risk elderly that their existence is meaningful and appreciated and that their well-being is important. All of this can be done through home visits or phone calls to provide emotional support.

Programs that focus on enhancing protective factors are still in their infancy and need further exploration. These include innovative strategies to improve social skills, interaction and communication, supporting the realisation of meaningful personal goals, enhancing quality of life by increasing empowerment and coping skills, self-esteem, sense of belonging, and meaning in life. However, programs aimed at improving the social lives of older adults should be respectful of the individual's desires and needs, as there are various ways in which they might choose to configure their social lives, for e.g., they might voluntarily retire, creating a mutual withdrawal expected by society (Disengagement theory); they might remain more satisfied with life the more active they remain (Activity theory); they might maintain some activity while disengaging from other activities (Selectivity theory); and they might follow the same path as their past experience, maintaining the same type of activities, relationships, and behaviours from earlier years (Continuity theory). In the absence of such programs, people such as Ratnakar are bound to fall between the cracks as they can neither completely 'disengage' nor maintain 'continuity', either through remaining fully 'active' or through 'selectively' choosing what they want to do. It is this lack of

choice that can lead to desperate measures such as suicide. Giving them this choice is the least that we owe our elderly.

CHAPTER FOUR

WOMEN AND SUICIDE

Dr Soumitra Pathare

The first and only time I met Mala Jadhav was in 2002. However, 18 years later, I still recall her vividly. I had returned to India a couple of years prior, at the turn of the millennium. My wife, a gynaecologist, and I had decided that after 10 years in the UK, we wanted to return to India and use our learning for the benefit of our people here.

I had started working in a large, 500-bed general hospital in Pune. After a lot of advocacy with general physicians I had convinced them that all cases of accidental and intentional poisonings and suicide attempts should be referred to a psychiatrist (me) before they were discharged from the hospital. The intensive care units at the hospital had started making these referrals very regularly and I had a very good relationship with the consultants and physicians who saw some value of the work I did with the suicide attempts prior to their discharge from hospital.

That chilly November morning, I received a message on my pager (yes, in those days struggling doctors like me could not afford a mobile phone and carried pagers)—*'Bed 6, ICU 23 y/o accidental OP poisoning. Will be discharged once seen by you. Family keen for discharge today'.*

This was not unusual. Most of the time, I would be asked to see the person on the morning when the physician in charge

thought they were fit to be discharged, and the family were usually keen for an immediate discharge and had to be convinced with difficulty to wait until the person was seen by me. I therefore kept my mornings free, to ensure I did see these patients before discharge.

Mala was 23 years old, and hailed from a village 50 kms from Pune. When I entered her ICU cubicle she was sitting up in bed, propped up by pillows, and the backrest of the bed raised. As was common with all ICU patients, she was dressed in a loose white and blue checked gown. There was an elderly woman, presumably the young woman's mother, dressed in the traditional nine-yard saree, as is common with rural elderly women around Pune, hovering around her in a very concerned manner and holding up a sipper from which Mala was sipping something, most likely coconut water. Don't ask me why, but relatives of Indian patients insist that any recovering patient should have plenty of coconut water! Visit any hospital in India and you will see plenty of street vendors outside the hospital selling tender coconuts.

As I entered the room, I requested the elderly woman to step out so that I could speak to Mala privately. The elderly woman seemed very hesitant and wanted to know why. At this point, and as was common, the ICU nurse intervened and explained to her that I was a doctor and needed to see the patient. The elderly woman seemed reluctant to leave but the nurse insisted and after adjusting the pillows propping up the patient, she dragged herself out of the room ever so slowly.

I was used to this routine as it happened every day. Relatives were suspicious of me for two reasons: one,

because I did not wear a white coat (a habit I had picked up working in the UK where psychiatrists never wore white coats), and two, because I insisted on speaking to the patient privately (with a nurse chaperone if it was a woman). I think there was concern if I was from the police department as attempt to suicide was a crime under Indian law in 2002, although recently the Mental Healthcare Act has tried to 'decriminalise' it. But I digress. More about the law later.

So finally we were alone—Mala, the nurse and myself. The nurse introduced me to Mala, drew the curtains of the cubicle, shut the glass door, and settled herself on a chair in the corner of the cubicle. Mala was born in a farming household in Beed district which is about 400 kms from Pune. She was the eldest of three siblings and had a younger brother and sister both at school. Her parents were subsistence farmers.

Mala was a petite, frail young woman with a darkish complexion common amongst those who work in the fields in the hot Indian sun. She had completed her education up to the 10th standard and had married (two years previously) into a relatively well-off farming family from a village near Pune. It turned out that the elderly woman hovering around her earlier was her mother-in-law and her parents were too poor to make the long trip from their home to see her in hospital. Her husband was the second of three siblings, he had an elder sister who was married to a blue-collar worker in Pune and a 24-year-old younger brother who was yet unmarried and lived with them.

I checked the hospital notes which said Mala had been admitted about seven days ago with 'organophosphate

poisoning’ and had required mechanical ventilation for two days. Organophosphates are common ingredients of many commonly used farm pesticides in India. When I inquired with Mala about it, she said she had a cough in the middle of the night and in the dark, she picked up a bottle, near where she was sleeping, thinking it was cough syrup and drank it. It was only later that she realised that it was ‘poison’ and so she woke up her husband who brought her to hospital immediately.

I had heard this story countless times before in my two years at the hospital. It seemed that Indian women had a particular predilection for drinking pesticides thinking it was cough syrup and almost always in the middle of the night. Anyone who has ever opened a bottle of pesticides containing organophosphate compounds will know that the noxious smell is something that will be felt a few miles away! I also haven’t understood why pesticide bottles are kept near to where someone sleeps and why women feel that gulping down a bottle of cough syrup if you have a bit of cough is the right thing to do.

At this point, I find changing the topic of conversation useful. I inquired about her family and we discussed the five buffaloes the family owned, which Mala helped look after and milked every morning. Her husband was a ‘social worker’ (did some work for a political party) and had a fancy motorcycle. We also spoke about her maternal family and she perked up a lot when speaking about her younger siblings. I asked Mala if she wanted to tell me anything more about the poisoning episode and she went quiet. At this

stage, someone knocked on the glass door and the nurse opened the door.

The elderly woman was back, inquiring “zala”, which in Marathi means “Are you done?”. The nurse told her we will take some more time and asked her to wait outside. This again was a very common experience for me. Relatives were always suspicious about what I wanted to discuss with the patient. Mala was quite well and they wanted to leave to go home.

I decided to end the conversation there, telling Mala I would be back later in the day to continue our conversation. I then had to explain to the relatives I was not allowing discharge that day, as I wanted to speak to Mala again in the evening. By then, the husband had appeared on the scene. He was a bit aggressive, wanted to know what I wanted to talk to her about, and said it was all an accident and I was unnecessarily creating ‘problems’. I had been through this a few times before too. I said they were free to take discharge and go but it would be against medical advice. I was not stopping them, but I recommended that they stayed until I spoke to her in the evening.

That evening, after finishing my outpatient clinic, I met Mala again. By now she was in a step down high-dependency unit (from the ICU) and all the tubes and intravenous lines were out. I explained that whatever we discuss was confidential and she was free to tell me anything she thought was important.

Mala started sobbing, after initially saying nothing was wrong. Apparently, her husband and she were trying for a child for nearly a year without success. They had tried all

traditional remedies to no success and finally her sister-in-law got her to see a gynaecologist in Pune two months prior. After many tests, it turned out that there was a problem with her husband—he was sterile. The doctor in Pune had offered some treatment options but the husband was upset and refused to go back to the doctor again.

On the day of the ‘accidental poisoning’, her brother-in-law sexually assaulted her and forced her to have sex with him. There was no one in the house that evening as her husband had taken his parents to visit his sister in Pune and only her brother-in-law and she were at home.

She was distraught and when her husband and in-laws returned in the evening, she told of the incident to her husband. She was surprised that he did not seem to be too concerned and said that maybe she misinterpreted what he was doing. She got angry and complained to her mother-in-law who tried to explain to her that the family needed a child and this would after all be her child and there was little difference between her husband and his brother who were very close to each other. No one would ever know, and she and her husband could have the child they both wanted so desperately.

Being a farming family, there were always pesticides at home. That night, after everyone slept, Mala swallowed a bottle of the most foul-smelling pesticide she could find. Very soon she started vomiting and that woke up her husband and the rest of the family. The overwhelming smell and her vomiting made her husband and the family realize what had happened and rush her to hospital.

Mala was insistent that she did not want anything done about it. She did not want it made public and she did not want to file a police complaint against her husband's brother. She had a younger sister who was yet to be married and it would harm her if Mala filed criminal charges against her husband and in-laws.

I made meticulous notes in her medical records. The next day Mala insisted she was well and took discharge.

I was disturbed by Mala's story and hence went and met a senior colleague to get some advice. After hearing my story he said, 'We are not activists. We are doctors. You should check if she was depressed and treat her for it.'

To be honest that disturbed me even more—where do we draw the line as clinicians, public health professionals, human beings?

The psychologist at my hospital always complained that I did not refer these suicide attempt patients to her for counselling. That evening, I asked her what she would do if I referred Mala to her. She said she would 'counsel' Mala, give her a space and time to express her grief. Fine, but what about the abuse? I felt she was distinctly uncomfortable discussing this issue—maybe she found it difficult discussing this with a man.

'It just appals me that we can treat women as chattel, as if they are unable to make independent decisions, that they belong to the men in their family or to their social groups. I think these are horrifying primitive ideas, how can you possibly imagine that this is going to be conducive for women to attain a sense of self-efficacy and well-being. The intolerance to freely choose one's romantic partners and the

violence meted out to those who form intimate relationships across caste and religious divides, is another blow to the need for autonomy and self-realization. If anything, our deeply conservative and orthodox social norms are the most toxic factors that contribute to suicide in young people,' says Professor Vikram Patel of Harvard Medical School.

In India, we have improved our maternal and child health services and as many young women do not die in childbirth anymore. More of them now die by suicide. Suicide is the number one cause of death for young women aged 18 to 39 years in India, ahead of maternal mortality. Indian women also die by suicide more often than women in other countries. While Indians make up approximately 18% of world population, Indian women account for 36% of suicides by women across the world (the corresponding figure for men is 24%), almost double the rate of women across the world.[1]

Research shows young women who die by suicide in India have a history of experiencing domestic violence including sexual abuse.[2] In India, women who are exposed to violence are three to seven times more likely to attempt suicide.[3] In a study conducted by World Health Organization in many countries including India, 64% of Indian women who had experienced physical violence from their husband or partner had also experienced suicidal ideation.[4] Unfortunately, India's National Crime Record Bureau (NCRB) includes 'physical abuse' in a broad category of 'personal/social' reasons for suicide, which accounts for a third of all suicides in India.

We know from the NCRB data now that suicides increased by 7.2 per cent in 2020 during the pandemic and frequent lockdowns. Researchers found that during the first pandemic lockdown in March-April 2020, complaints about violence against women increased 100%.[5] It would be good if the NCRB specifically explored the relationship between suicide among women and their experience of violence during COVID-19 lockdowns when they publish the 2021 suicide data next year.

In Mala's case, maybe she was also depressed. But that is beside the point, in my opinion. Mala attempted suicide within a few hours of the sexual abuse incident. Depression would hardly explain the reasons for her suicide attempt. Sexual abuse will give rise to grief symptoms and many symptoms of grief overlap with depressive symptoms. We should be careful in not labelling grief as depression.

'I have always maintained that suicide is just not a mental health issue, it's also a social issue,' says psychiatrist and suicide prevention researcher, Dr Lakshmi Vijayakumar from Chennai.

Duleeka Knipe is a UK-based suicide researcher at University of Bristol and works on suicide prevention in Sri Lanka. She says, 'You can treat somebody for depression and anxiety but if they are living in a household with extreme violence, you know, what you are doing then is not necessarily going to reduce their risk of suicide, or self-harm. It's challenging that and trying to shift it and change the lens a little bit to refocus on social determinants being as important as clinical factors.'

Analysis of NCRB data over a 10-year period from 2001 by Rakhi Dandona and her colleagues shows ‘marriage related reasons’ account for 8% of women’s suicides while this was attributed to only 0.8% of men’s suicides—a ten-fold difference. ‘Married women account for the highest proportion of suicide deaths among women in India,’ said Rakhi Dandona and her colleagues in their 2016 paper on gender differentials in suicides in India. There is an old adage in mental health that marriage in general is protective and leads to better outcomes for a range of mental health conditions for men but is damaging for women. Why is this so? While we do not have conclusive evidence for any particular reason, scholars have pointed to issues such as early and arranged marriage (India accounted for one-third of child marriages in the world in 2014), early pregnancies and motherhood, lack of economic independence and domestic violence.

Where women live in India also seems to matter when it comes to suicide. Women’s suicide death rate in six states, Tamil Nadu, Karnataka, West Bengal, followed by Tripura, Andhra Pradesh and Telangana, was more than 18 per 100,000 in 2016. Only three countries in the world had a higher women’s suicide death rate. There is also a ten-fold variation in the suicide death rate for women across states in India. As with a lot of things to do with suicide in India, we do not know why this is so.

It is also worth noting the role that the media, especially TV serials and movies, can play in preventing suicides. Dr Lakshmi Vijaykumar says, ‘Many Tamil serials would show a woman in crisis, domestic crisis, she would immediately go to

the kitchen, pour kerosene and set herself on fire. Self-immolation. It's just such a horrific method. So, I spoke to AVM Saravanan and some other serial producers. All agreed not to show that as a method in any of their series, it has been stopped in the last seven or eight years. The number of self- immolation in women has come down drastically in Tamil Nadu since then.'

Professor Vikram Patel of Harvard Medical School makes an important point when he says 'Policy should recognize that not everyone or every group in the population is equally affected by a variety of different social determinants. An obvious example would be gender based violence. Women are disproportionately affected by interpersonal violence and interventions that are seeking to reduce suicide in the population must recognize the specific vulnerabilities faced by women which is going to need a specific set of policies to reduce suicide in that subgroup.'

A month after having seen Mala, I remembered she was supposed to return for a follow up and had not shown up. I asked the hospital social worker, a feisty young enterprising woman, to find out her whereabouts. A couple of days later, she reported that since the telephone number was not reachable, she took the address and went to the village (it wasn't far—took her a couple of hours' bus journey). The address was incorrect. There was no one by that name and family in the village. Villagers were also not aware of anyone with that name in the neighbouring villages. Obviously, the family had given a false address.

I never saw Mala again. I have always wondered what happened to her. Did she attempt suicide again? Is she alive?

If she is, she would be nearly 40 years old now. Is she still with her husband? Is she happy? Did Mala get any justice, after all?

I have not forgotten Mala. It is a daily reminder of my helplessness as a psychiatrist and a public health professional to help women like Mala in these situations.

CHAPTER FIVE

DRINKING TO DEATH

The Alcohol Problem

Dr Abhijit Nadkarni

I am an addictions psychiatrist by training, one of a very small professional tribe in India. We are trained in the treatment of people with the complex medical, psychological, and social needs arising out of addictions to both substances (e.g., alcohol, cocaine) and behaviours (e.g., gambling, gaming). In my clinical role, the commonest addiction I come across is that to alcohol. Not surprising in India, as it is the second most common substance of use after tobacco. What is surprising is the fact that we do not pay much attention to a substance which directly and indirectly affects large swathes of the population in an adverse manner. To this day, I remain amazed by the reluctance of our policy makers to deal with a substance which is causally related to more than 60 different medical conditions! I cannot think of any other single risk factor in the world which can have such an impact. This does not include the adverse social impact and costs of alcohol to families and society at large. One such condition to which alcohol can play a contributory role is suicide.

As he stands on the parapet wall of the bridge, a small vestige of doubt starts appearing in the deep recesses of

Jatin's brain. But, that is promptly extinguished as the familiar alcohol fueled brain fog takes over again.

The idea that alcohol and suicidal behaviour are related is not a new one… though it is more common to see a romanticised description of its properties vaunted in literature. Throughout most of his life, Ernest Hemingway, arguably the greatest American writer of the 20th century, had been a heavy drinker. In his classic book, *A Farewell to Arms*, he eloquently writes, 'The martini felt cool and clean… I had never tasted anything so cool and clean. They made me feel civilized. I had had too much red wine, bread, cheese, bad coffee, and grappa. I sat on the high stool before the pleasant mahogany, the brass, and the mirrors and did not think at all.' This could well be a reflection of Hemingway's own life in which his relationship to alcohol was driven by a strong streak of self-destructiveness. As Anthony Burgess wrote in Hemingway's biography, 'The physical punishment he took from alcohol was… actively courted.' In 1961, after being released from a mental hospital, Hemingway died by suicide using a shotgun at his home in Idaho. If ever there was any doubt, today, this relationship between alcohol and suicides stands substantiated by a growing number of research studies.

In academic literature, alcohol problems are classified into several categories based on criteria such as patterns of drinking (how much, how many, how frequently one drinks), impact of the drinking (on self, others, society) Drinking to Death etc. However, let us keep this simple and lump them all into one category of 'heavy use'. Although there are some finer nuances of how those various categories play out in

relation to suicidal behaviour, we will focus on the higher-level relationships. Let the academics fight over the subtle differences!

Heavy use of alcohol is one of the key risk factors for death by suicide and suicide attempts. Of the suicide burden that is attributable to the whole range of mental and substance use disorders (and trust me, there are quite a few), heavy alcohol use is second only to depression as a contributor to that burden. But how big is the risk? After recent consumption of alcohol, the likelihood of a suicide attempt is on an average seven times greater as compared to someone who has not consumed alcohol, especially when greater amounts are consumed.

Although data from India is limited, we can understand the following broader patterns based on whatever information is available. Compared to those who have not consumed any alcohol, those who have are at almost 19 times greater risk of attempted suicide— at par with neighbouring China and Mexico, but far greater than many other developing and developed nations.[1] Young people are not spared either. If you are a school-going adolescent, then the likelihood of suicidal thoughts is almost two times if you have consumed alcohol, compared to those who have not.[2] Amongst those with attempted suicide admitted to hospital, one in eight of the attempts are made under the influence of alcohol, often with the patient having little to no recollection of the actual circumstances surrounding the attempt.[3] Finally, overall, alcohol use is a key factor along with others such as socio-economic circumstances, interpersonal, social and cultural

conflicts, financial problems, and unemployment as significant risk factors for suicide in India.[4]

My clinical journey with Jatin started when I first met him as a middle-aged person seeking professional help at our NGO. But the origins of his problems lie in his growing up years in a rapidly globalizing India. As he was growing up in the India of the 1990s, Jatin saw a fascinating change happening all around him. With wide-eyed wonderment he watched as economic liberalization brought with it a sweeping change in the way people lived their lives. The way they ate, travelled, and shopped. Those were exciting times for an impressionable young person. He remembers how thrilled he was to first watch MTV or walk past a McDonald's, even if he could not afford to eat in one at that time. It was a decade of goodbyes: to audio cassettes, Walkmans, and boxy Ambassador cars. It was also a time for firsts: watching a diminutive Indian batsman from Mumbai boss over the cricketing firmament, listening to a musical genius from Chennai churn out world-class music, watching American soaps on cable TV, and sleek Japanese made cars on the roads.

Amidst these visible changes, what went virtually unnoticed was a strategic and insidious campaign by multi-national alcohol companies to target a huge emerging market with a rapidly burgeoning young population. India did not stand a chance in the face of this assault. It gradually started to shed its historical inhibitions about alcohol as a lifestyle choice. And what is emerging out of this continuing socio-cultural flux is a signature pattern of alcohol consumption which is characterised by predominantly male

drinking (only 2 out of every 100 women in India drink alcohol), frequent and heavy drinking, especially of spirits (and not beer or wine), bingeing (drinking large amounts within short periods of time), and solitary consumption with the aim of getting drunk. Consequently, when it comes to alcohol consumption, India continues to move against the wider global trends. While alcohol consumption across most of the developed world stabilised between 2010 and 2017, India bucked that trend. Over that same period, alcohol consumption in the country increased by a whopping 38 percent—from 4.3 to 5.9 litres per adult per year.

Those were heady times! Jatin was in college. Friends and fun dominated his life. And as usually happens in college, one day he was introduced by his friends to the potent pleasures of alcohol. Initially he resisted, but his friends were insistent. Eventually he relented and realised that his friends had been right; he was able to have so much more fun after a drink or two. Amazingly enough, the alcohol also helped him to come out of the intermittent morose moods that he was prone to. Without him noticing, his pattern of drinking started to change over time. From drinking on weekends, he gradually started drinking on a few days of the week as well. On a few of those occasions he would end up 'smashed' and had to be dropped off home by his friends.

Independent of long-term drinking patterns, acute heavy alcohol use (e.g., intoxication) plays an important role in suicide in two ways. Alcohol intoxication leads to disinhibition, and this in turn can facilitate suicidal thinking. The increased impulsivity that can accompany intoxication

can lead to behaviours without due consideration to consequences. Put these two together and what we get is a potent situation which enhances the chances of suicidal thoughts being acted out. This has been borne out by studies which demonstrated positive blood alcohol concentrations among a large proportion of suicide completers, and alcohol intoxication leading to a manifold increase in suicide risk compared to abstinence. Interestingly, the tendency of employed heavy drinkers to die by suicide over weekends has been partly explained by the direct effect of alcohol intoxication. Additionally, intoxicated individuals are more likely to use more lethal means to attempt suicide—means that generally have a very low probability of survival, e.g., firearms.

And then love happened. Jatin's life was changing. He met Sanaya at his workplace. He was working as a clerk in a bank and she joined as a newly recruited cashier. It started off innocently enough with meetings over lunch, and quickly evolved into coffee dates after work. And before they knew it they were married. They moved to a new city to set up home. Away from family and old friends, they got to spend quality time with each other. However, the honeymoon period did not last for long. Married life brought with it new challenges. Away from friends and family, they began struggling with the responsibilities of independently running a household. The initial few months of marital harmony gave way to frequent arguments and sometimes violence. Jatin started seeing a new side of himself. When frustrated with the situation, unable to express his emotions, he tended to lash out—verbally and physically. He

started spending more time away from home to avoid the arguments at home. Evenings after work were now being spent at the local bar. Large amounts of money started getting diverted from essential household expenses to drinking and related activities.

Reliable estimates indicate that alcohol consumption in India is going up. Generally, suicide rates in a country go up as the per capita consumption of alcohol rises. However, usually this relationship is not so simple. Multiple socio-cultural and environmental factors influence suicide rates, and that accounts for the variations in rates across the world. One such factor is the patterns of drinking. For example, Sweden and France have completely different drinking patterns and alcohol consumption in the former is more strongly related to suicide than the latter.[5]

Broadly we could categorise these factors that interact with drinking to moderate the effects on suicide into those that exist within individuals and those that exist outside of them. Existing characteristics of individuals that influence the relationship between drinking and suicide include ‘externalising’ (projected outwards) factors such as aggression and impulsivity; and ‘internalising’ (experienced internally) factors such as low mood and feelings of hopelessness. Greater the severity of these factors, greater the risk of suicide in the presence of alcohol use. For example, if one is impulsive by nature and a drinker then the risk is greater as compared to someone who is impulsive but does not drink. Precipitating and external factors that add to this risk include stressful life events, interpersonal difficulties, poor social support, living alone, other substance

use (e.g., cocaine), and serious medical illness. Especially in the context of alcohol use, disruption of relationships, male gender, older age, and having a mood disorder (especially combined with increasing age) is also strongly associated with suicidal behaviour. But this is a relatively simple conceptualisation of complex relationships. So, let us try to understand some of these characteristics in slightly more detail.

One school of thought is that the wider ‘drinking culture’ in a country can influence the association between heavy drinking and suicide. But what exactly is ‘drinking culture’? Macro-sociologically, one way of dividing drinking cultures has been into ‘dry’ and ‘wet’, and an influential idea is that ‘dry’ drinking cultures would be more strongly associated with suicides than ‘wet’ drinking cultures. The drinking culture of a society is determined based on drinking levels (e.g., total amount consumed), drinking patterns (e.g., rates of drunkenness), social control of drinking (e.g., restrictiveness of alcohol control policies), and the alcohol-related problems in that society. In dry drinking cultures, alcohol consumption is not common during everyday activities (e.g., part of meals). Access to alcohol is more restricted, there is low per capita consumption, alcohol control policy is more restrictive, wine consumption is less common, and overall abstinence is more common. However, when drinking does occur, it happens over short periods (e.g., weekends), it is more likely to be heavy and to result in intoxication. Stereotypical examples of traditionally dry cultures are the Scandinavian countries, like Sweden. In contrast, alcohol consumption is integrated into the daily life

and activities in wet drinking cultures. In such cultures, alcohol is widely and easily available, there is high overall level of drinking but distributed evenly over the week, abstinence rates are low, restrictions on alcohol availability are limited, and wine is largely the drink of choice. Stereotypical examples of such countries include the southern European countries bordering the Mediterranean (e.g., Italy). Applying these parameters, contemporary India could be categorised as a dry drinking culture.

There are two main mechanisms through which we can explain the closer relationship between alcohol consumption and suicide rates in dry drinking cultures like India. One reason is the *greater rates of drunkenness or intoxication* in such cultures. As we discussed earlier, the state of intoxication increases the risk of suicide. Hence, we would expect a stronger and closer link between alcohol use and suicide in dry drinking cultures. The other key mechanism is the acceptance of heavy drinking within a society. Generally, there is a greater acceptance of heavy drinking in wet drinking cultures. The reactions from people around the drinker is an important factor which determines whether the drinker perceives alcohol as a personal problem and of subsequent development of suicidal ideas. The lower acceptance of high intake of alcohol in dry cultures makes heavy drinking behaviour more stigmatising and marginalising, and thus more strongly linked to suicide risk. Furthermore, since heavy drinking and intoxication is generally more prevalent among men and younger age groups, one would expect a stronger connection between heavy drinking and suicide in these groups.

Sometimes, when all of it got too much and his mood hit rock-bottom, Jatin would sit back and reflect on how his life had panned out. He was born in and spent most of his early years in a mofussil town of North India. His father was heavily influenced by the prohibition movement initially emphasised by the nationalists during India's Independence struggle and which survived till the mid-1960s before losing steam. Jatin's early memories were of living in an environment that frowned on alcohol and indeed looked at is as something indulged in by people with loose morals and weak self-control. Much to Jatin's surprise, although Sanaya grew up in a city, her beliefs, long moulded by a family that similarly frowned upon alcohol, were similar to those held by his own family.

Jatin's views about drinking, however, had changed over the years. Time spent at the University and subsequently migrating to the city had exposed him to a different world. All around him was messaging that directly or indirectly indicated to him how drinking was 'cool' and 'normal'. His friends in college were doing it, and so were Bollywood stars in the movies. Bacardi was selling cool music CDs and organising dance parties. Kingfisher was making calendars with pretty women models, and pushing the 'King of Good Times' tag line for their beer. In all of this, Jatin was furiously trying to negotiate these two worlds, one which looked down on alcohol and the other that looked at it as a lifestyle choice. He could not understand what the big fuss was, but had to adapt himself to the environment and people around him. He couldn't afford to upset Sanaya or his ageing father. At the same time, he could not deny

himself the pleasures of a chilled beer or relaxing rum and Coke. However, Sanaya's disapproving looks and not-so-subtle comments about his drinking was making it increasingly difficult for him to drink at home or indeed spend a leisurely evening out with friends. The only way out for him was to nip into the local bar after work for a quick couple of drinks, before going home. He would get a rapid buzz and that helped him tide over the inevitable argument that would start when he reached home.

Another key ecological characteristic that one cannot discount is the *alcohol policy environment* as that also plays a role in connecting alcohol use and suicide. There appears to be an inverse association between alcohol taxation and the suicide mortality rate. Although there appear to be some variations by gender and type of alcohol, generally, greater the taxation and consequently higher the price of alcohol, lower the population level suicide rates. Similarly, easier the access to alcohol through greater the number of liquor outlets, higher the rates of suicide. This association between the density of liquor outlets and suicide rates is especially true among young male adults. Besides reducing the access to alcohol, measures to reduce the adverse consequences arising from acute consumption of alcohol also have an effect on rates of suicide. Zero tolerance laws prohibiting drivers under the legal drinking age from drinking and driving, is associated with a decline in suicides among both young men and women. Interestingly, these zero tolerance laws also reduce male suicides for those aged above the legal drinking age. It is quite possible that this occurs because the extensive publicity of these efforts and stringent

enforcement results in less alcohol consumption across all young age groups and not just among the targeted age groups. Most of this evidence comes from the United States of America where variations in alcohol policies between its various states provides for opportunities to compare their effects. Evidence from other countries, although limited, supports the influence of alcohol policy environment on suicide rates. A collection of alcohol policies implemented in Russia included those aimed at controlling the volume and quality of alcohol products and sales, to requiring the registration of alcohol production and distribution facilities led to a reduction in male suicides, but had no effect on female suicides. On the other hand, policies that led to privatisation of retail sale of alcohol and rapid rise in private liquor outlet density in some parts of Canada showed significant increases in suicide mortality rates.

However, such relationships between the alcohol policy environment and suicide rates are not always clear and straightforward. An evaluation of the Lithuanian government's series of alcohol policies strengthening regulation of alcohol advertising, limiting alcohol accessibility, drunk driving control, etc., showed a paradoxical increase in suicide rates among men. This was contrary to expectations. However, this unusual finding could be explained by the economic recession happening at the same time that these policies were introduced, which resulted in a major spurt in unemployment. The increased psychological distress and heavy alcohol use resulting from this unrelated event might have resulted in increased suicide rates, despite the reduced alcohol availability resulting from

the new policies. Hence, it is important to remember that such policies do not exist in a vacuum and their outcomes are influenced by what is happening in the larger ecosystem within which they operate.

Independent of alcohol use, *psychosocial stressors* are very frequently observed in many people who die by suicide, and these most commonly include interpersonal losses and conflicts, chronic physical illness and financial problems. On the other hand, independent of suicidal behaviour, there is a strong relationship between such stressors and heavy alcohol use. But how does this play out in drinkers with suicidal behaviour? In heavy drinkers, stressors such as lack of social support, unemployment, serious medical illness, and living alone have been seen to cluster prior to suicide, cumulatively increasing the risk of suicide.

Co-morbidity, or the co-existence of more than one disorder, is common in suicide completers, especially substance use disorders co-occurring with other disorders. The most commonly co-occurring conditions in completed suicides appear to be heavy alcohol use and depression, with co-occurrence carrying a markedly higher suicide risk than either of these disorders alone. These two conditions appear to work additively or synergistically, resulting in a disproportionately high suicide risk among patients with both disorders compared to those who have only one of those. The rates of heavy alcohol use is generally greater in depression compared to the general population, to those not having depression, and to those with physical health problems such as hypertension, diabetes, or heart disease. However, the mechanisms which connect heavy alcohol use and depression

with suicide are complex and not fully clear. Broadly we could separate these mechanisms into physiological (related to the body) and psychological (related to the mind). The physiological mechanisms mainly work through neuro-transmitters ('chemicals' that act as messengers of information in our brain) that play complex overlapping roles in the development and/or effects of heavy alcohol use, depression, and suicide. The psychological mechanisms could be further sub-categorised into the following: (1) the adverse interpersonal and social problems resulting from heavy alcohol use increase psychological distress, hopelessness, loneliness, and depression all of which lead up to suicide; (2) alcohol enhances or facilitates aggressive behaviour, which in the case of suicide manifests as aggression towards self; (3) suicidal ideation arising from hopelessness and helplessness felt in depression is fuelled into action through the impulsivity resulting from heavy drinking; and (4) suicidal behaviour arising from depression could be avoided through effective coping strategies. However heavy alcohol use leads to narrowed attention which reduces perceived potential solutions to a binary (immediate solution vs dying by suicide) and excludes alternative solutions that could inhibit suicidal behaviour.

Gradually, Jatin's drinking started affecting his life beyond his marital relationship. And this is when I first met him at our clinic. At that time he was increasingly drinking by himself and consequently alienating his few remaining friends. To avoid arguments, he started spending more time away from home. Finally, Sanaya could not take it anymore and suggested that they separate. He had to move out of

their house and rent an independent apartment. The stress of this added financial burden and the feelings of loneliness set him on a downward spiral of hopelessness and helplessness. He had been experiencing intermittent periods of low moods for quite some time but now these periods started becoming more intense and sustained. Although he had been making some progress in therapy and had reduced his drinking, this social and emotional upheaval was one blow too many. His immediate reaction was to drink more. This numbed him emotionally and helped him forget his difficulties for the time that he was drinking. However, he would wake up in the mornings with bad hangovers, feel guilty about his drinking, and vow never to drink again. Inevitably his work performance started to suffer. He would arrive late to work, make errors in the accounts, and sometimes miss workdays as he was too hungover to report for work. Finally, the pink slip arrived in his inbox. And that was the proverbial straw that broke the camel's back!

Another important mechanism that possibly links heavy alcohol use and suicide is '*alcohol expectancies*'. Very simply put, alcohol expectancies are one's beliefs about how alcohol may affect one's behaviours. Our understanding of an individual's alcohol expectancies can help explain why that individual drinks alcohol. These expectancies could either be positive (e.g., 'alcohol will help me to relax and make socialising easier') or negative (e.g., 'alcohol use will make me feel guilty'). As one can imagine, generally, positive expectancies will be associated with increased drinking, while negative expectancies will be associated with less

drinking. When it comes to suicide, alcohol expectancies come into their own once the decision has been made to end one's life. Once the stage has been set, the suicide-specific alcohol expectancies might help to propel the thoughts into determined action. This could happen in several different ways. One expectancy is that alcohol will give them the motivation to die by suicide and the acute effects of alcohol intoxication is expected to help one overcome the natural restraints against dying by suicide. Another expectancy is that alcohol will help them to die painlessly. This belief might resolve the ambivalence that often precedes suicidal behaviour, and in fact might be one reason that leads people to choose a more violent, and definitive means of dying by suicide. Thus, besides alcohol as the direct method for suicide (e.g., taking an overdose and drinking to intoxication), the suicide-related expectancies that lead to incorporation of alcohol into the suicide plan include gaining courage, numbing of fears about the means of suicide, and anesthetising the pain of dying.

Now that he was unemployed, he started filling up his day with drinking. Getting into a drunken stupor was helping him cope with his situation. However, it was also eating into his meagre savings. Any attempts that he made to get a new job were at best half-hearted. Sometimes, after a few drinks he would muster the courage to call Sanaya, and try to reconcile with her. But she was having none of it. And inevitably their conversation would quickly spiral into a shouting match. As things around him worsened, his drinking increased, and his dark moods became more frequent. Such moods were now accompanied by a flicker

of a thought: 'What is the point of continuing? My situation is not going to improve.' The thought would be gone as soon as it appeared. When he would recall that thought during sober moments, it would scare him. In his heart, he knew that he would not do anything to hurt himself. The mere thought of ending his life scared him. It was at this time that Jatin started to slowly disengage with therapy. He would want to end sessions abruptly, and miss them entirely on occasion.

Last, but certainly not the least, is the complex relationship between alcohol, aggression/impulsivity, and the *neurotransmitter*, serotonin. Aggression/impulsivity is associated with deficiency of serotonin, and also with alcohol. Heavy alcohol use is associated with increased aggressive behaviour. For example, greater the number of days of heavy drinking, greater the chances of perpetration of severe episodes of intimate partner violence by married or cohabiting males.[6] Alcohol use also exerts its effects on aggression and suicidal behaviours through serotonin. Very simply put, alcohol reduces serotonin activity. Lowered serotonin activity has in turn been shown to be tied to increased aggression/impulsivity and enhanced probability of suicidal behaviour.

As the weeks passed, Jatin found himself getting increasingly caught in a vicious cycle. The breakdown of his relationships and loss of his job was constantly playing on his mind. He was finding it increasingly difficult to handle the stress caused by his situation. However, alcohol was turning out to be his trusted ally in these circumstances. It was reliably helping him forget his difficulties. But, at best,

this was temporary relief and his drinking started to increase in an attempt to extend the periods of relief. As his situation became dire, the distressing thoughts about putting an end to it all continued to increase in intensity. Although the fear of dying kept him from taking the drastic step, he did not see any immediate solution to his current problem. At this point he completely disengaged with therapy and stopped attending follow-up appointments with me.

Thus, alcohol use could be related to suicide through one or more different mechanisms. The drinking culture of a society and the policy environment in that society create the ecosystem within which the various individual level internal and external factors interact in several ways leading to the final act of suicide. Alcohol use may directly lead to suicidal ideation and behaviour through impulsivity. Suicidal ideation may affect alcohol use through attempts at self-medication, e.g., expecting the increased drinking to relieve the feelings driving the suicidal thoughts. Or both of these might be happening at the same time. Alcohol use may not directly influence suicide but may aggravate other factors (e.g., worsen financial situation or relationships) that affect suicide. Alcohol use and suicidal behaviour may not be directly related but there might be some third factor which might be associated with both, e.g., depression might be leading to increased drinking to relieve the low mood and also driving the suicidal thoughts. Just as with a lot of other risks for suicide discussed in this book, the relationship of heavy alcohol use with suicide is complex…but real.

As he stands on the parapet wall of the bridge, a small vestige of doubt starts appearing in the deep recesses of Jatin's brain. But that is promptly extinguished as the familiar alcohol fueled brain fog takes over again. And then he takes the plunge…

CHAPTER SIX

MARGINALISED AND AT RISK IN INDIA

In Conversation with The Blue Dawn Founder, Divya Kandukuri and Sappho for Equality Member, Koyel Ghosh

In 2021: A school student is found dead by suicide, and the bereaved family was reported[1] saying she was depressed as her school didn't let her take her exams, since they couldn't afford her school fees.

In 2020: A second-year college student dies by suicide,[2] reportedly leaving behind a note saying she doesn't want to be a further financial burden to her family; after struggling to flag concerns about lack of resources (hostel accommodation in the national capital, a laptop for online learning).

In 2020: A 14-year-old girl from Kerala dies by suicide, her family reportedly saying[3] she was unable to attend online classes as the family couldn't afford a smartphone.[4]

In 2016: 26-year-old PhD student dies by suicide in a case widely-reported upon[5] by the national and international[6] media, sparking off wide-spread protests in the country of his birth. He had left behind a letter reportedly penning some of his thoughts (heartbreaking and eloquent) about his birth feeling like a 'fatal accident'. Less widely reported or commented upon,[7] perhaps, was the fact that eight other Dalit students had died by suicide in the same institute over the past decade.

In 2008: A 22-year-old medical student dies by suicide,[8] mentioning caste-based discrimination by a professor.

Say their names: Sanjana Devi, Aishwarya Reddy, Devika, Rohit Vemula, Jaspreet Singh.

All of them were born Dalit in a country which tries to tell itself it is post-caste, a country which prides itself on the demographic dividend that will churn the multi-million dollar economy and ensure it is one of the rising Asian giants. Take a moment to reflect on the vast disparity that encompasses and engulfs, extinguishing in one cruel moment the hopes and dreams of entire families, communities.

It is all too easy to reduce the issue of suicide to one impulse, one moment, or mental illness (the prevailing model in the West). It is so much harder to confront the socio-economic realities and cruelties we perpetrate on the marginalised in our country.

To quote an article by Mehnaz Zarin in *Feminism in India:* 'An analysis of NCRB (*National Crime Records Bureau*) data from 2016 revealed that the highest incidence of suicide are among Christians, Dalits and Adivasis in India.'

Deepa Pawar, the founder-director of the Anubhuti Trust, a youth-led organisation, shares some of her own lived experience as the daughter of a parent who attempted suicide. Having lived 30 years of her life in the slums of Mumbai, she talks of the 'intersection of unending deprivation, restrictions by the joint family, and extremely strict patriarchal norms within the NT-DNT (Nomadic and Denotified Nomadic tribes) community' to which she belongs.

She highlights some clear nuances and differentiators when it comes to marginalised versus privileged communities and reporting on suicide.

‘In ground communities like ours, there is no information or understanding of suicides. There is a lot of violence within the community because of the way our practices, behaviours, even thoughts and memories have been twisted and broken to fit us into the casteist system; and of course systemic and social violence from without. Because of this there are multiple suicide attempts. However, there is a palpable fear of suicide reporting in communities like mine. In privileged communities too people fear the need to report suicides due to their name and honour, but here the fear is because we are already criminalized, seen with constant suspicion and treated as criminals by the police; the fear that any excuse for them to investigate us will turn against us is real.’

Pawar shares that, ‘In oppressed castes, many a times, the cause of suicides never gets properly known. Communication and documentation about a matter like suicide is so less that the people who die by suicide, die silently, their reasons getting buried with them. People don’t talk about their mental health, even if they do they don’t have much language to express and articulate. Their discussions don’t get documented, what they are feeling or facing are not recognised as mental health issues. In short, symptoms of mental health and therefore suicide are invisible in ground communities.’ She highlights a common myth on how we stereotype when it comes to suicide—‘If it is about a youth, reasons are immediately assumed to be related to studies or to love relationships. In case of women, her ‘character’ is

questioned. In case of men, his problems related to job or livelihood are assumed. But the root of the matter, or the fact that there might be more than one issue, or a series of issues are not considered.'

Blue Dawn is a community initiative that recognises the complexity of the challenges and the chilling realities of being Dalit or Bahujan or Adivasi (DBA) in India. It's worth quoting from their site:[9]

'Blue Dawn is a mental health care support group for Bahujans (Scheduled Castes, Scheduled Tribes, Other Backward Classes, Nomadic Tribes, Decriminalised Notified Tribes across religions), which believes in community healing. Mental health is a social issue, especially when it comes to the marginalised sections. We do not agree with individualistic approach of mental healthcare in the West as well as in India. We stress the need to form solidarities and assure people living with mental illness that they are not alone in their struggle.'

Blue Dawn founder Divya Kandukuri (now in her mid 20s) grew up in Ongole, a coastal town in Andhra Pradesh, and went on to study journalism at Lady Shri Ram College, Delhi University and Media and Cultural Studies at the Tata Institute of Social Sciences, though she took a break after a year of her master's degree, dropped out and started Blue Dawn. She works as a journalist and in social media for different organisations and is clear that there are defined structural inequities that have to be addressed, that mental health has to be seen as intersectional.

'So first of all, most of us coming from oppressed backgrounds and marginalised sections don't know this

language of mental health,' she tells us. 'We don't know about therapy, we don't know what counselling is, we don't know about psychology and psychologists. This even from my experience, I only know that there are mad people and there are sane people, and the mad people go to asylums, sane people are sustained. This is how our Indian cinema also showed us what mental health is, right? So from my own experience, that's how I believed what mental health was, until I got to go to Delhi University, that is just 0.5% of our population who gets to go for higher education, right. So people still don't know this whole world of the language of mental health that's used in textbooks.'

Then there is the experience of discrimination, a fundamental lack of understanding from others, and even further trauma when approaching a therapist who isn't aware of intersectional issues, or who might deny the role that casteism has to play in one's mental health.

Which is how Blue Dawn came to be, Divya says. 'Blue Dawn started as a community, as a group of friends coming together wanting to share their experiences across this nation, at university spaces or workspaces. So on WhatsApp chat, it's just people from across the country. That group was more of a support group for us, how we began. All of us had similar experiences at university spaces or at workspaces, where we were reduced to our identities, caste, and the kind of discrimination (we had to face). So we used to just talk, share our experiences, because then you go to a therapist—this actually happened, most of us are also people who have access to mental health services—and we tried going to therapy or going to a psychiatrist, but none of them

understood what we are trying to say. Like one of the experiences was like… I got 97%, but still, people in my class used to say I got in through reservation.

'… There are many people like me, who got further traumatised by therapists. So there is a gap in the mental health practice in itself, the structural issues are not taken into it… the approach is very individualistic, right. So, most of us were also tired of that individualistic approach. So, we thought we need community healing rather than the clinical healing. That's how we came together. And that other group started and then people started asking us to recommend a therapist, so what we thought of doing is, we set up a system where we have certain therapists, people who we went to, so basically to round up the list of people we trust, and we facilitate it. Now we have a website, if you need it, if you need to access therapy, you can go to our website, and you can fill in the form and we also sponsor therapy sessions. Because, again, therapy is not accessible. So we also sponsor therapy sessions. And the other thing we do is we conduct trainings and workshops on caste and health, we worked with youth, initially, we worked with various kind of youth from marginalised sections, and we had to stop the project because of COVID and the funding was over. But in general, we do workshops and trainings on caste and mental health. We also train mental health professionals or social workers or activists on caste.'

Following is a lightly edited transcript of our conversation with Divya.

What is Intersectionality?

American Professor Kimberlé Crenshaw first came up with this term and calls it a 'metaphor for understanding the ways that multiple forms of inequality or disadvantage sometimes compound themselves'[10]—this could include how race, class, gender, caste, religion, and other social identities overlap, 'intersect' and can compound disadvantage.

On Intersectionality in India

Divya: It's also not just about caste. Again, there is another intersection of gender, there is sexuality, right. And there's always a lot of talk around queerness and therapy, and how therapists should be queer affirmative. But there is no talk on (casteism)… I don't think before Blue Dawn, people did talk, but *itna* openly, I have never witnessed—people saying, okay, caste matters in therapy rooms, and all that.

… There are multiple gaps. One considering that mental health practice is apolitical, I feel that is so wrong. That's where it all goes wrong. We believe that mental health is political, when we say mental health, we mean the whole set of discourse to practice, right? Also the fact that a therapist should not bring their political opinions into therapy rooms. Again, that's also a myth, because we feel that personal is political, right, and if you are a casteist, if you are a homophobic therapist, you will show it in your face. So this is what I feel, I wonder all the time, people who are casteist and homophobic, they practise therapy, and they still say, *mental health is, like it's so hard to be caste affirmative and queer affirmative*. When it's so easy to be casteist and homophobic, why is it hard to be affirmative, right, for other people? So this is something I've seen in trainings also.

I hate when people say, '*Oh, this workshop has been enlightening*.' My, our workshop shouldn't be enlightenment, because this is the reality that surrounds you. And if you are from a social science background, and you studied psychology, you should be knowing this already. So that is the condition of psychology and psychiatry in this country, also, because it's still dominated by the Western philosophies and Western ideas, which completely ignore the social, economic, and political realities of India.

And the other gap that we noticed when we say access, it's not just about money or knowing the therapy and all that. It's also the quality, right? The quality of therapy, okay, you set out 100 helplines and say you can access it anytime. That doesn't mean that is helping me. As I said it, therapists are still being casteist and are homophobic, there is no way for us to access that, right, when we speak about access, I feel we also need to talk about the quality and how the therapists are sensitised to provide services. So all these influence our work as well, all these gaps have also influenced how we work at Blue Dawn.

Q: Right. So we are talking to a certain extent about how caste and other social determinants intersect with access to good quality mental healthcare. And how it also intersects with the counsellor or the therapist's perspectives towards this. What about the other end? Which is basically how does caste intersect with the development of mental health problems, the progression of problems, the maintenance of mental health problems? Do you have any thoughts on that?

Divya: So I don't know if you read this book called *The Cracked Mirror* by Gopal Guru and Sundar Surkkai, that beautifully puts certain points down. I'll give you an example. There is a student going from a small town to Delhi University. And that student, even before going to university, from their school life itself, has been told that because they avail reservations, they are somewhat… How do I put it? That they don't have that calibre to perform certain tasks, right. Especially in medicine, for example the recent case that happened of Payal Tadvi and as well as one more case that happened in 2020. These doctors have been told that because they came from reservation (category), they don't deserve to be there. They link their performance to availing an affirmative action—that has been told to them for so long. So, I mean, like, Gopal Guru very beautifully writes, how the body language of our student changes, when they're in front of someone who is from the dominant upper class and which is so real, it happens to me also. Like, my language changes, how I speak and how I stand and how my shoulders are, you know, all of this changes.

Just like—it's a very bad example—I have a dog, so I can see when she's not confident enough or when she's scared or distressed, her tail goes under her legs. It's showing the trauma through the body. And a similar thing happens to people from marginalized sections, even women, right? Women cannot speak loudly in a patriarchal household after a point. Their voice lowers voluntarily, like it's just, by default, it happens, because of the abuse, years of abuse. And we have experienced it, inter-generationally; like generationally it

has been there and generationally our students have been told that they're not good enough. And they don't belong in classrooms. We only got access now. Like we are the first generation mostly… first or second-generation university going students.

So all of this, like there is so much literature on what happens to children and people post-Holocaust, like people who experience that or people coming from Black communities. Why can't we apply the same thing to people coming from oppressed castes, as it can be totally applied. It's just that Indian academia does not want to believe that caste exists. So that's the only thing.

That is one and there is not just caste to it right, there is, again, patriarchy, capitalism, there are too many systems. So I would like to quote Bell Hooks from this book called *Ain't I A Woman*, in the introduction of the book, she explains how Black women are oppressed on three layers—by White men, by White women and by Black men as well. Right? So it's three layers of oppression that Black women are going through. And when she said that she meant cishet, able-bodied Black women. If we were to add ability to it, that is again another layer of oppression; if we were to add gender to it, there is again, like gender and sexuality again, there is another layer of oppression, right?

So similarly, (in) our society… it's a layered oppression. I believe that all of it has manifested into trauma.

I hate doing this, but I'll just give two examples. When Sushant Singh Rajput's suicide happened, the whole country said that it's nepotism… I mean, everyone spoke about nepotism for those four or five months, not just one month, it was four or five months. But when Rohit Vemula died, people said that he was depressed. Every news media said that he died because he was depressed. When Payal Tadvi died, they said she was depressed. When Anita from Tamil Nadu died, people said she was depressed. So this is how deaths are also looked at. Right? When this one Rajput man dies, everyone started becoming progressive about mental health and said that suicide happens because of the system. But when people, when students from marginalised communities have been dying—not once, they have been dying for years—everyone says that they died because they were depressed. So I'm not denying the fact that they might be depressed, but who is causing that depression, does not get spoken about, when we die.

It’s not that people don’t know; people know. When they can quote nepotism (as a reason) for a suicide, how hard is it to quote casteism for suicide? It’s just that they don’t want to acknowledge it, people know that the reason for suicides is the system. It’s just that you don’t want to acknowledge it. As Rohit Vemula says, (the) cost is also in our death, in our life, in our streets…

And it’s so sad that his letter is still relevant even after four or five years.

Q: So what you’re basically saying is that when it comes to marginalised communities, we tend to sanitize the narrative by adding a very medical term to it…

Divya: Yeah, what am I trying to say is it’s not that people don’t know that structural inequalities influence mental health. I used to believe that people didn’t know, but throughout that period of Sushant Singh Rajput’s death, everybody knows that structural inequalities influence mental health. It’s just that when it comes to caste, people do not want to acknowledge that it exists, because the minute they acknowledge it, the upper class will lose their power over many things. And the hegemony and the structure will start to crack down, because they want to hold on to that structure. When it comes to us… it suddenly becomes individual, suddenly becomes that ‘*There is something wrong in our (individual) body*.’

Q: I would like to narrow that down a little bit further to now, suicide, and how caste plays a role in that… your thoughts on how caste intersects with that, how caste plays a role and how it also interferes, if it does, with seeking and accessing help for any suicidal thoughts or plans? Because we have to accept that in India, it’s not just mental health that leads to suicide, but there are also a lot of social circumstances…

Divya: You want me to speak about the social aspects of how caste intersects with society. There are many intersections, here, again, there are many instances of suicide cases. One of the recent examples is again, the student deaths… Say, Anita is from Tamil Nadu and she scored 99 percentile or something. She wanted to become a doctor, and suddenly the central government forces NEET across the country. When you study from state bodies, you study in non-English medium, and medical terms in English differ so very much from like, in Telugu. If you are from Telugu medium, it will take you years to understand the English terms and vice versa. But the central government introduced this NEET, which is the same for everyone. So even a student coming from a remote village and a government school will have to write the exam and a student coming from Delhi will have to write the exam

and we know who the winner is. In such a scenario, it's so unequal, even it's so bizarre, but that that has been forced upon the student and she killed herself. I don't think it's suicide. It's a model by the state because you are driving the student to death.

And one more example, very recent, of a person coming from a lower income group. She's from Hyderabad, her parents are a tailor and a rickshaw driver, I think. She was in my college, LSR. When the COVID-19 lockdown happened, she couldn't afford a smartphone. She couldn't afford internet, we know how much internet costs, like I pay 6,000 rupees for a six month plan, and how can… someone's income is INR 2,000 per month, how will they afford Wi-Fi, right? So, but Delhi University can't take that into account and it started holding classes. And this kid was in so much turmoil because she couldn't tell her parents that she needs the internet. She needs laptops, she needs a smartphone. Because in her letter, she wrote a letter, she said that I don't want to be a burden on you. And that is the… that is again, we can't call it again a suicide, right? She didn't want to die. She died because Delhi University didn't let her attend, didn't give her a laptop, didn't give her internet, didn't give her any scholarship to afford her education. This lockdown in itself was very unpredictable for everyone, even in that scenario. The colleges were running… So she died, and she died because she didn't want to be a burden. It's not because a screw was wrong in her head. Right? It's because, again, it's a model, institutional model, by the educated, the university spaces. So we have many such real life examples around us where the state or the system in itself drives people to take their life and someone was telling me how someone took their life because they couldn't see the injustice around them. And they didn't want to be part of this. That is so unequal. So all these things. There is this really nice video that we use in our Blue Dawn workshop, called the Unequal Opportunity Race. It's made in a race perspective.

In that video, they speak about housing segregation in the USA. Even in India, we still have housing segregation, right? Because for a student, I'll just give my example, me and my mother… We don't have our own house. We have rented houses, we still rent. But we never told our (caste) to any landlord so far, (laughs), because that's just how it is, it's so hard to find houses and especially when you're a single parent, on top of caste and religion. In Mumbai, you don't get houses if you're a Muslim. It's so evident. There are, in Mumbai, different elevators in housing complexes for domestic workers. And it's so normalised, right, if people don't see it as a problem and imagine that you are a child of a domestic worker and you are seeing your mother

being treated (like this). You're getting different utensils to eat, you're getting tap water to drink and you're using a different elevator; it's basically untouchability right, and you are the child witnessing this happen to your mother and yourself. You don't think that will influence how you perceive the world and how you… (lose) the will to live, in a situation like that. And it's just very pathetic.

I don't know if you've watched I'm sorry, I quote so many things! So if you see, there is this scene, in *Fandry*, which is a Marathi film… that kid goes through all sorts of oppression. That's a beautiful film that talks about patriarchy also, beauty standards and everything, and caste. And so in the climax of that film, the kid picks up a stone and closes in on the screen… Yeah, that stone is for the whole audience, right. That's, that's for us. You're watching the film. And that kid was never angry throughout the film, was never angry, he was just a very calm, idyllic kid. And he gets so much anger in him by the end of the film, because of the injustice that happens in front of his eyes. And that's just how it feels like, for real, that film shows how it literally feels in our bodies. The way he picks up the stone, that's exactly how I feel all the time.

Like, you know, picking up the stone and throwing it. And in reality, if someone does it, if someone responds, acts upon that body's response of picking up a stone in anger, they'll get jailed, they get tagged as witches in villages, women from lower castes are labelled witches and are thrown out of villages. This happens in Maharashtra to date. Especially the Palghar district, and all of those coastal areas… So lower caste people and women have been responding to their bodies, like acting upon their body's response toward an injustice, and they're being jailed or getting beaten, or getting lynched for responding to the injustice. And in such a world who has the will to again, live, you know, if you don't have enough support around you, it can definitely lead to suicide.

As I said, it's not like people want to die. It's just… it's the last resort. They just don't know what else to do. That's the only solution they have. And that's what happens. I look at suicide as a response; as a response to injustice, as a response to oppression.

When you tried all the things, for example, Anita went to the Supreme Court —she was a 15- or 16-year-old girl, she went to the Supreme Court, took this case on NEET, she tried all she could and she could not do it further. She had to kill herself… I mean, everybody tries and no one wants to die. All our students who died so far, even Rohit. He was protesting for so long. Then,

his scholarship was cut, his hostel room was taken away from him, he was sleeping on the road, along with his friends. He tried all he could, and when he could not do anything further, that's when he had to kill himself. Right? So I feel it's just the injustice and oppression. And our body responds to that. And there is always a… I won't call it a breaking point. It's just one of the responses to… Just like how people, how Jabya picks up a stone and throws it. Some people kill themselves. That's, that's how I look at it; highly controversial but yeah.

Q: Thanks Divya. That's framing the issue very eloquently, and thanks for that. So how do we, in your opinion, how do you think we could respond to this differently? Quite obviously, from everything that you've said and from what we know, we are not doing that. Responding to this issue about suicide in India, in your opinion, how could we do this differently more generally, and then more specifically in relation to caste?

Divya: We did this one post on Blue Dawn… No matter how many affirmative practices we get, how many helplines we bring—that is *toh* there, I'm just tired of saying it again and again, that's it—but I feel the ultimate thing is to work towards annihilation of caste, right?

You might think it's a very large thing that I'm saying, but I feel that is the need, like even after these many attempts, why is nothing… (being done?) Why are our students still dying? That's because the caste system is still prevailing, right? The system is what I feel you need to pluck from the root and the root is the caste system. And the solution is annihilation of caste and I feel that Indian psychiatry and psychology it's high time (to) come to the ground, come to reality, which is India, and start working towards what—and because leaders have already said, there is nothing new that Divya is going to say today—because our leaders have already articulated this years ago, through generations. I mean, Savitribai Phule, Jyotibai Phule worked and then there was colonization, there was caste system that was rampant; Ambedkar worked (against it). There are many leaders who already gave so many solutions. They wrote so many books. And the answer is in those books; answer is in their activities. Right?

I just can't comprehend the fact that Indian psychology students don't read about the caste system as a chapter. They read gender, they will read Angela Davis, they will read race, they just don't read caste and how bizarre is that? You are living in India, not America. So that is again, like a solution. Read about caste, inculcate (that) in the course itself. And I don't think except for TISS, because TISS has foundation courses (and TISS in itself has

evolved through years), if you go to any commercial college that is teaching psychology, you won't see them reading even feminist theories. Forget caste, they don't even read feminist theory. So how will that person who becomes a psychiatrist or a psychologist behave in the therapy room? They're going to be horrible. And, yeah, again, that's what I'm seeing. We need to talk about caste 24x7, because things are not changing. That's because we are not working on the root cause and I feel that root cause is caste, and the solution is annihilation of it.

Q: I think the big picture message is also important. All of this has been extremely useful. I mean, you narrating all of these issues, using illustrative examples, connecting it to movies, books, videos, social media, I mean… This is what is very useful rather than having an academic conversation, so please don't kind of pull it down. I think it's been extremely useful, personally for me, and I think for the book. So yeah, thank you very much. Are there any final thoughts that you might have before we finish?

Divya: Yeah, I think, again, no, I have this thing in my head that I couldn't give these pointers, this happens to me all the time. That's because I'm very tired; of doing things as in like, I've seen so many organisations doing so much work on getting helplines, giving trainings to their counsellors doing this, doing that. But I've seen it, that's why maybe, that this person will get a training on caste in mental health. But in their own household, they'll still marry the person from their own caste, then still take dowry, they'll still give separate utensils for the domestic worker. So what I'm trying to say is, we have to look at it as a circle, as a cycle, right?

No, this person gets a training, now becomes this queer affirmative caste affirmative therapist, and goes, practices, but again, goes back to the house, separate utensils for the domestic worker, that means that domestic worker, will develop mental health issues, their children will develop mental health issues. So basically, I say, there is no end to it, right? Even if I'm being progressive in my therapy room, but I'm being casteist in my household, I am creating people who will have some mental health issues. I'm driving people towards death with my prejudice. So until I stop that, I don't think there is a solution. That's all.

II

The LGBTQIA Community and Suicide

In Conversation with Koyel Ghosh, Sappho for Equality

In their own words, Koyel Ghosh is a non-binary, nonconforming person who joined Sappho for Equality, a Kolkata-based NGO in 2013, and is now a managing trustee. They are also a full-time educator, teaching at a private international school.

Here is a lightly edited conversation of Koyel's conversation with Sonali Kumar for this book.

Koyel: Sappho for Equality was a queer collective that was formed in the year 1999 by six lesbian women who tried to form a safe space for other women-loving-women people in the city. Basically, looking at a safe space for people where they can openly talk about their sexuality, about their desire, without the fear of being judged, without the fear of exclusion, without the fear of discrimination. So that's where Sappho for Equality started. And in 2003, it became an NGO and became registered as a charitable trust. Now Sappho for Equality has been here for almost 20 years. We work for lesbians, bisexuals, and trans masculine people. But we also, in the course of our work, sometimes come across other segments of the LGBTQ+ plus community, which is sex workers and trans women and some variations also. So that is where the purview of our work lies.

We've done multiple amounts of research on LGBTQI issues. We still have the collective, which is functional. We also have a helpline which was started in 1999 and at the time it was difficult for people to (find someone to speak to). Nobody had access to mobile phones. So we had a landline number during specific times that was given and people could anonymously call and express their desire to be a part of the collective. Their anonymity was of extreme importance because at that point, as I understand, confidentiality was a big, big issue and a big, big challenge. So that is when all of this started and we still have a crisis helpline number.

Phone

+91 33 2441 9995 (12 pm–8 pm except Mondays)

Helpline

+91 98315 18320 (12 pm–8 pm except Mondays)

We also have a short stay space, a crisis intervention space that is functional from the time of the pandemic. The main intent behind this crisis intervention space is because a lot of people are thrown out of their natal homes. One, due to their sexuality or their gender identity, so their sexuality and gender identity comes to the forefront. So a lot of women will get thrown out of their homes or face extreme amount of violence from their family. So when they leave their home, we want to make sure that they have a space or a roof above their head for at least three months, which is the time that we allow people to stay.

On suicide and the LGBTQI community

We've done some research, which was called the Viomap, where we tried to trace the kind of violence meted out to GSM population from the years 2003– 2009. We saw that a lot of people from the LGBTQI community are driven to suicide because of many reasons. So we also have counseling services for the community. We have queer affirmative counselors with us. We frequently make suicide prevention videos because a lot of people in the community are driven to suicide, sometimes not just because of family pressure, because of nobody understanding them, because of the loneliness and the fear of being outed without their consent. There are times when people also choose to end their lives because there's no other option for them.

And access to education and access to livelihood are difficult for the LGBTQI people because once they come out of the closet, a lot of discrimination is meted out to them in terms of job opportunities, in terms of educational opportunities, in response to their dignity and right to life, which is often denied to queer and trans people because of their gender identity and sexual orientation. There's always a fear of forced marriage, which is, mainly, I will not say completely, but mostly against PAGFB, which is person assigned gender female at birth.

So, a lot of people are forced into marriages without their consent and they are forced into heterosexual marriages that they don't want to get into and they're unable to tolerate the kind of trauma and, you know, the kind of trauma and the kind of—trigger warning— the kind of rape that happens. And sometimes they resort to suicide. So that happens. And a lot of times, you know, broken relationships and relationships in the community often tend to be fragile because of the lack of institutionalised (support), you know, the relationships are not accepted by the society, even if 377 (is repealed). So, a lot of times relationships break. And that also leads to suicide.

Q:The kind of work that you do spans multiple levels and the fact that you're doing suicide awareness videos, you're doing counselling services, you have a shelter home, peer support, do you feel like there are services out there similar to yours that are accessible for people? Or do you feel like this is a huge gap in the service landscape?

Koyel: I agree that there is definitely a gap. There is very less amount of services and, you know, places people can resort to, because not everybody's OK with accessing counselling services. You know, sometimes they just need a peer, a friend to support them. And then because in India, the queer spaces are very limited and they're very independent, and so there's not much collective spaces for people to vent their anger or frustration or their pain.

So to counter that, to challenge that, to fight that, we tried to open up our space and our collective and our organisation to people who want to be associated with us in different ways. But the cases of suicide are rampant in the LGBTQ community because of many kinds of marginalization, be it caste, be it class, gender, sexuality. There's so much resistance from all sectors that young people, young adults do not really have enough resources to keep them afloat, and sometimes they resort to something as extreme as killing themselves.

You know, in 2011 we made a Bengali film titled *Ebong Bewarish* (and the unclaimed) on a couple's suicide, where two women were in love with each other and lived in one of those villages near Nandigram in West Bengal. One of them was married, but they were in love with each other. And by the time we did get the information, they had already committed suicide. It was strange that their bodies were found together tied by a towel, and they had both drunk poison to kill themselves. And that was how the bodies were also found.

This is also a reality in today's time, though there is access to social media, this is also accessible to a privileged few people, right? For people outside the purview of social media, which is in the districts, in the villages, same sex practice is a reality, but it is so regressive and it is so problematic for them to talk about it, or to fight it, that sometimes resorting to suicide seems like the only option. By regressive I mean the mindset of people, how they view same-sex, queer or trans relationships as a deviation from the norm, and the sort of violence meted out to people when they come out. And that's why we can come in and we try and reach out to those people— if at all the call comes before the act is done—to try and save them. But there are many times that the collective faces defeat. Maybe you've spoken to somebody for an entire night and the next morning the phones aren't getting connected anymore and we realise we've lost the person and it's extremely traumatizing. Even talking about it is very triggering.

Our engagement is also on social media. We have, you know, sharing sessions where we share meeting IDs openly with our followers and they come and talk in sharing circles, listening circles, in the empathic communications that are done where we as activists, who are also from the LGBTQ community, we talk about our experiences of being there on the borderline and being able to come up, or cope, with that situation, I think that gives a lot of comfort.

But I honestly have that hope that someday, that there will be no more LGBTQ identified people committing suicide because they could not reach out or find somebody. Maybe there will be one day that nobody has to die because they did not have anybody to speak to. Absolutely. So that is our intent and that is what we are working for and working towards. And I'm very hopeful and I think that is what… I think that is my purpose in life and our purpose in life, as Sappho for Equality.

Q: Given the kind of work that you do and how broad it is, what is the ideal for you in terms of what India needs to do? Do you have any recommendations? Not even recommendations, but dreams as to how we need to change our response to LGBTQIA+ suicide in India? So at any level, at the personal level, at the clinical level, at a systems level, what needs to change in India for us to be able to respond to this better, to prevent it?

Koyel: Yeah, I think actually more and more queer affirmative counsellors need to be available, accessible and free. That's one. It has to be first accessible, second, available and third, there has to be monetary compensation for this; one has to understand that for this, not everybody

can afford a thousand rupee per session fee, that is not the majority of the population. So that needs to be taken very, very seriously by NGOs, CBOs (community-based organisations) and even the government has to come up and rise up to the occasion and do something about that, that's one.

I think number two is that apart from the inclusion of LGBTQI people in the mainstream, I think if the framework of society changes; if the framework of society, which constantly violates and discriminates against the mindset of the people, until and unless there's a sea change in that, all of these efforts are futile. Not futile, I would say, but half-hearted, because there needs to be a sea change in the mindset of the people, in the mindset of the people employing you, mindset of the people providing you education; mindset of the people who are with you as your natal family, the nature of that support.

You know, nobody wants to kill themselves. I was speaking to someone who was about to do something drastic and I asked her, without taking names, that you know, don't do it, we're right here. And she said, *'I can't see you. You're one thousand kilometres away from me on a phone call. You know, I wish there was somebody here holding me, telling me not to do this and maybe I won't.'*

And I understood that she needed somebody around; somebody who she could believe in, trust or rely on, somebody, a family member; it could be a friend. It could be somebody who understands what drives a person to something as extreme as killing themselves. Every call that we get, it's a call for help because we know that when somebody picks up the phone and makes that phone call, they're giving you a chance to save them, and giving themselves a chance to save themselves.

And, you know, to reach to that point can be curtailed at different levels. If there was even one person to speak to; if there was a job that the person would take up; if there was education but with no discrimination and marginalisation, I think the person would not be driven to a situation like this. And even if the person is driven to a situation like this, if there was access, if there was a phone call that they could make, that could probably comfort their broken soul, I think then (suicide can be prevented).

CHAPTER SEVEN

FARMER SUICIDES

In Conversation with the Founder of the People's Archive of Rural India, P. Sainath, author, Everybody Loves a Good Drought, and with Duleeka Knipe, a UK-based suicide researcher at University of Bristol, who works on suicide prevention in Sri Lanka

The challenges posed by inaccurate data, the crux of the issue when talking about farmer suicides and why this is much more than an agrarian crisis.

The issue of farmer suicides feels at once both complex to unravel, as well as fundamentally simple to understand where we have failed. India has failed her farmers. This is a clear developmental and humanitarian issue, affecting millions of people, more than three hundred and twenty thousand of whom have ended their own lives in the last 20 years. As the *Economic and Political Weekly* put it in June 2020, 'By any development parameter and the right to livelihood, suicide by 3.22 lakh Indian farmers in the last two decades is not a small number.'[1]

This is a 'calamity of catastrophic proportions', one of India's best-known voices on the topic—P. Sainath— tells us, sharing that one farmer is taking their life every 32 minutes. According to the data (of which more later) the states of Maharashtra, Karnataka, Kerala, Andhra Pradesh (now AP

and Telangana) and Madhya Pradesh report 63.3% of the total number of farmer suicides in the country, though Chhattisgarh and Odisha also report acute distress in these categories.

And yet.

We have a challenge when it comes to the data, and another challenge when it comes to the national-level response. We have had no sustained reaction or major policy level changes when it comes to an evidence-based approach, like restricting access to highly toxic pesticides (means of committing suicide), an approach which has been successful in Sri Lanka and Bangladesh.

We have more inappropriate or inadequate responses, even from policy-makers, who react by attempting to compensate families with farm loan waivers or ex-gratia payments post a suicide, which has the unfortunate consequence (some say) of potentially incentivizing the truly desperate (*at least my family will be taken care of)*, instead of helping address the root cause of the crisis. It's easier to talk about stress and depression perhaps, than think about the systemic issues and determinants that are crippling our agricultural industry and workforce— those in the field or those who have worked on the issue will talk more about the fundamental issues that connect on the ground—crop failure, finances and resources, as well as access to care.

This is not—as most of us might initially think—an issue fundamentally to do with mental illness, though of course there can frequently be elements of depression and distress. In India, it's impossible to look at this crisis without noting the social determinants, the economics of it, the financial

hardships that farmers have to face (that date back to the change in agrarian policies but are compounded by each new wave of hardship, each new loan taken to tide over a season, and each cycle of unfair pricing that have exponential consequences).

As you'll see from this interview with noted journalist, Ramon Magsaysay Award-winner, author of *Everybody Loves a Good Drought,* and founder of the People's Archive of Rural India, P. Sainath, the numbers themselves are problematic. He says we may never know the true scale of the crisis, with the actual numbers likely to be three to four times higher than the estimates doing the rounds. He terms it a moral crisis, a civilizational crisis even, where the tragic series of suicides of farmers is the symptom, not the cause.

Almost as soon as we start our interview, Sainath shares a startling anecdote as an aside. He estimates that he has visited more than 900 households over the past 21 years, where farmers have died by suicide. This included '53 households on the trot' in one phase of reporting. (Though he keeps himself out of his stories, he does share that the subsequent trauma has shattered his own health, across various parameters.) What keeps him going is that if he doesn't do the stories, the stories would die out in the media, he tells us matter-of-factly, while moving on to demystifying the important issue at hand.

First, a major point on the data: there was no data on farmer suicides until 1995 in India. Starting that year, this data starts to be reported and collated by the National Crime Records Bureau (NCRB), though problematically, it didn't look at agricultural workers/ farmers as a category;

secondly, when it starts, it's looking at data from the 1991 census—before the agrarian crisis begins.

'The third thing about it is that it's looking at nationwide figures and drawing conclusions on farm suicides, which are concentrated in six states. It's like, if I were trying to determine the literacy rate of Kerala from the all India literacy rate,' Sainath says. He goes on to share the errors of omission—reflective of our societal biases—that crept into the data-collecting by surveyors/ researchers/constables/tehsildars, where for example a woman would not be categorised as a farmer in her own right (we are still calling them 'farmer's wife'/ 'widow', rather than 'farmers' though they do a huge proportion of the work on the farms). These are errors of omission, reflecting the 'warts and pimples of our society', Sainath argues, which have little to do with the NCRB, which collates that data.

Until 2013–14, that is, when he says that politics started having its influence, after there is more sustained media attention on the issue (in no small part thanks to him and his colleagues reporting on the numbers and the scale of the tragedy). Sainath shares that he believes there was a push to the NCRB to reframe its methodology and break it up into different categories so the farmer's suicide numbers look less.

Post 2014, the methodology of the NCRB questionnaire changes dramatically, and in fact, there are a lot of changes when people start being classified as tenant farmers or agricultural labourers. After 2011, state after state start

declaring zero suicide, he shares, and in fact that number isn’t quite believable.

‘After 2014, 12 states, six union territories are randomly declaring zero suicide which is physically, statistically, socially, impossible. Then comes the division into categories. Essentially, what the NCRB are having to do is find different places to park the corpses. And you know, anyone who works with data knows that the ultimate burial ground is a column called Others,’ Sainath tells us. ‘For example, Karnataka. [In] Karnataka, there is a dramatic fall from ~1500 (1,403) figure to 340. Okay. And there is an increase in the “Others” column of Karnataka of 245%. Now, in the six major states, which account for 70% of the suicides, the suicides have fallen by 62%. The “Others” column has gone up by 128%.’

The methodology change also means that the new data (2014 onwards) is not comparable to the older data (1995 onwards). Not just that—how about how we classify deaths due to suicide? Given that pesticides (very lethal, with levels of toxicity much above those sold in other countries) are easily accessible to farmers?

‘We realise that it is easy to misclassify pesticide suicides as accidental deaths, yes. Whereas you can’t misclassify hanging as an accidental death. It is far difficult to put hanging as an accidental death because drowning, you know, drowning, and pesticides go down as accidental that’s far more common, whereas, you know, hanging can’t be and so hanging appears as a big cause of method of death,’ Sainath says.

He takes a trip down memory lane to share a very important finding that he and a colleague uncovered years

ago. ‘Dr K. Nagaraj, formerly of MIDS, interpreted the data for me, which I was bringing in from the field as well. He pointed out many years ago, in fact, he had a small presentation on it. He had a very simple argument and was devastatingly accurate. Up to 2011–12 you’ll see that, and even definitely up to 2007, there is a huge mismatch between farmers suicides, and pesticide deaths and pesticide suicides. Okay. Now, this is crazy, because (for) farmers, the chosen tool of suicide is pesticide. It’s free, it’s there in your home. I mean, you don’t have to go out and buy it.’

What’s Going On with the Data

‘Now there’s a huge gap between the number of pesticide deaths and reported farmer suicides, in Andhra Pradesh. When we started… 1999, 2000, 2001… I’m credited with it, but M.L. Narsimha Reddy is the guy who cottoned on to the fact that something gigantic was happening and called me in on it, and we did stuff together. Now, we found the evidence completely contradicting the District Crime Records Bureau (DCRB)… How data is collected (is that) every police station in the country, gathers its unusual death data and files it with what is called the DCRB. All the districts of a state file to the State Crime Records Bureau.

‘… We said look, we want all the files that were filed and which have gone into the “Others”. We want this. Now the standard causes of suicide, you know, unrequited love affairs, marital dispute (which in the Telugu translation reads very cutely as “husband wife misbehaviour”). Okay, marital

disputes, unrequited love affairs, students failing in exams—these are very specific.

'But would you believe that all those reasons, accounted for less than 5% *of the suicides in* Anantapur and "Others" accounted for 58%? So we started dissecting the others. FIR after FIR showed us; now all the data has gone, okay; but FIR after FIR showed us, you know how they classified it? Suicide due to unbearable stomach ache. Now, if you drink Monocrotophos (insecticide), I guarantee you a terrible stomach ache. They turned the process on its head! Hmm, that he killed himself because of an unbearable stomach ache. He had an unbearable stomach ache in the process of killing himself, but they turned that on its head. Do you know how many? Hundreds. So I wrote a piece that day, I mean on that trip, you know, "Never have a stomach ache in Naidu's Andhra Pradesh, tummy aches are terminal here!"'

'You know, I can tell you that two people who had a severe stomach ache that day, were Narsimha Reddy and myself, like stumbling on a mass grave… and we realised that we were sitting on the top of a volcano; that of some 600 suicides, hundreds were due to stomach ache? *Pottan-oppy* in Telugu, means tummy pain. Then we saw that all these people had taken their life, going backwards to a household with Monocrotophos. Free input there. Then the newspaper started reporting, in Andhra, that Monocrotophos is the major tool of suicide. Now, Nagaraj shows you that between 1995 to 2007, the number of pesticide deaths, suicides, vastly outstrips the number of farmers' suicides, which means that a number of farmers' suicides are being shoved

into that category. So, if even the pesticide suicides are an underestimate, then you're looking at an agrarian holocaust.'

It doesn't end there.

'A large number of farm girls' suicides get classified as "student suicides"… I did stories on two or three of them—as the agrarian crisis gets worse, parents sending children to school or college have to take a decision. Who do they get to drop out? The girl. Now, the girls whom I saw, they were class toppers, they were you know, fanatically wedded to study. The brother is too often a mediocre dimwit because he's a spoiled son of the house. You remove the girl from studies, she dies by suicide, it's a student suicide. She has not failed an exam, she has bloody topped the class. The injustice of it is just…

'There is a problem of what I call—this is my own construction—recording of the last cause. We will never know. All this tells me that we will never know the scale of farmer suicides that took place. We can only guess that it is three to four times what we have recorded.'

Why Does India Have So Many Farmer Suicides?

'Every suicide is the final result of a multiplicity of causes—maybe three or four—but when 300,000 people from the same occupation commit suicide, you need to step back and think of it,' Sainath argues. 'Whether one or more of those causes, was a driving cause, was more important than the other causes, important to the extent that if it were not there, the suicide might not have occurred.

‘What happens is a guy, usually a guy, is getting into debt. And by the way, that is very seriously farm crisis-linked, and it is very seriously policy-linked; from 1991 we changed our policies on agricultural credit very dramatically. Agricultural credit is diverted towards agribusiness and corporations (earlier the farmer was getting institutional credit after the Green Revolution).

Please understand two myths.

1. One, that drought has caused the suicides. There have been sometimes very high suicides in excellent monsoon years, too.
2. Another thing, that the suicide was caused by failure of crops. I’ll show you 100 instances where there’s a wave of suicide after bumper crops, because of a price crash.

So, the (farmer) … has multiple loans. I did one interview here with a guy who was juggling 15 to 17 loans. At some point the balls have to come down. And he was a guy who had never known debt before this crisis began. The crop fails on top of it, he is unable to repay his instalments. He is going through hell, he is not getting loans from banks, the moneylenders are squeezing him for the instalments. He is unable to pay the family’s bills. His kids have to drop out of school or college.

One day he is accosted in the village square by the *sahukar* (moneylender) who slaps him around in front of everybody. Humiliation and dignity are very important factors in suicides, as any human being knows. Now, this has been a building volcano of tension and stress in him. That night, he gets drunk, goes home, beats his wife, the first time he’s ever done it. And he kills himself. In several such cases, I

have spoken to the wife. And she says, “He never hit me before. He never hit me before.” And she said, “Getting drunk—I haven’t seen him do that, I’ve seen him do that once in years. Not like this.” The police are going to record marital dispute as the cause of it. So, that is the recording of the last cause. This is my own phrase for it, that this has a significant distortive impact on data: recording the last cause.’

Don’t Like the Data? Change the Goalposts

‘There are two more methodological issues, which you need to be familiar with. The first and foremost is, “Who is a farmer?” You can make the ratio of suicides higher or much lower, depending on who you define (as a farmer).

‘The farm suicides are linked to the point that it’s not just that agriculture has collapsed, the farmers’ universe has collapsed. I’ll give you a very simple point. If you are from a rural area yourself, you will know it. In the 60s and 70s, the status of being a farmer was something far greater than that of being a doctor or an engineer.

‘And in Uttar Pradesh, in my home state, I can provide you physical evidence with hundreds of interviews where you can go and talk to people yourself. In the 60s, 70s, early 80s, if a father was looking for a husband, bride groom for his daughter, and he had a choice between the son of another paddy farmer with 20 acres, family acres, which means per capita three to four acres, and a doctor, engineer or a local government servant, he would choose the farmer. By 2000, no farmer would give his daughter to a farmer’s son and no

farmer’s father would look for, except in desperation, to get the boy married and have a next generation, they would also avoid farm marriage, because the status, that dignity has gone. That dignity had gone in 1973 in Maharashtra. You open your Income Tax Ready Reckoner… You look at the back of it… There is a list of gold prices from 1951 onwards, correct. Nowadays, I think they’re doing it from 1970 or something, but the older income tax rate in Vidarbha, a farmer could sell one quintal of cotton and buy 15 grams of gold. In 1973, you could sell one quintal of cotton, and buy 15 grams of gold. Today, how many quintals of cotton do you have to sell to buy three grams of gold?! Something is going to give.

‘One, his economy has collapsed. Two, his status has collapsed. And that is a very serious factor in my mind for suicide.

‘There’s another thing that I want to tell you to get a picture of how horrendous this is. Now, the Government of India agrees that 330,000 farmers have taken their lives in two decades. Without getting into the causes they agree that 330,000 farmers have taken their lives. The same police tells me whenever anytime I go and have a discussion, the ratio is even higher… One suicide means at least seven other attempts. Dr Lakshmi Vijayakumar (from SNEHA) told me she believes that is nonsense, it’s closer to 15 or over… So just think about it. Let’s say it’s, let’s say it’s 20. If 330,000 people killed themselves, how many people have tried to do that? If one person every 32 minutes was taking his or her life between 2001 and 2011. How many (made the attempt)?

We’re talking about millions. I think you have a calamity of catastrophic dimensions on our social scale.’

The Politics of It

‘You know, Dr Narendra Jadhav did a survey on farm suicide to respond to Dr Nagaraj and me, in our work of 2007 where Nagaraj used the phrase, and I agree totally, “Maharashtra is the graveyard of farmers, on every indicator”. So, Jadhav did an on-demand survey without meeting a single farmer, a study of literature. And there was very little about actual farmer suicides and a lot about me (P. Sainath), because that was his task. So he ended up saying, “Sainath says totally, factually incorrectly, ‘Maharashtra is the worst in farmers suicide’, this is not true. We are not the worst, we are the fourth worst.” Okay (laughs).

‘This is like, I told him, you know, it’s like the child going home and telling the parents in this exam, I was not the bottom I was fourth from the bottom. So that’s a huge improvement. But you know, who the first two were, first three were? Pondicherry and Goa. Okay. Now, please understand what happens in the stupidity of farmers suicides numbers. You can, see, when people are committing suicide on that scale, absolute numbers are important, but they are not enough. Percentages are important. I’m saying what Dr Nagaraj divided was four ways of checking the intensity. One, the absolute numbers. Two, the percentage of farmers in a given place, killing themselves. Three, the ratio of farmer suicides to general suicides. And four, the ratio of farmer suicides to non-farmer suicides.

‘I think you’ll agree that this will give you a far more balanced picture, which is the method I’ve always fought for. And I’m not taking credit for it. I was educated on that by Professor Nagaraj. As I said, my background is that of a historian, I understand farmers, I understand people who live on farming. I’m not an agriculture expert. I’m an expert on people who live off agriculture.

That’s who I know and understand. Whatever little I know about the science of agriculture, I know from them, and I don’t say that’s a great deal. But I know that I know how they live on the land. So now, if you don’t take this, you just take percentages—if there are three farmers in Malabar Hill and one committed suicide, that is the highest rate of farmer suicides on the planet. In the US, by the way, I found there was a suicide of a farmer in Beverly Hills that should be the worst rate in the world. Yes. But, it was one of those hobby farmers, okay. So, this is one thing… So, the percentages by themselves can be very misleading, but they are important to have along with other factors. Now Puducherry and Goa put together in 10 years did not have the farmer suicides of Maharashtra, because there are very few farmers in Puducherry and Goa.

‘… The second thing he took, was he said, farmers suicide should not be counted in percentage as against the number of farmers. It should be taken against the person population of the country. Now try calculating say, child labour, like this!’

What Data Doesn’t Show: The Bigger Picture

‘Let me tell you about one medical team that came together around 2006. And they were really motivated, well-motivated doctors and medical professionals moved by the suicides and they went about doing their study systematically, talking to the people in the village, etc.

‘But they had been totally disconnected from the ground realities. In one village, an old gentleman, farmer I knew, and I met him. They asked questions and then made notes. He said, “*Main bhi appse kuch sawaal pooch sakhta hu? (Can I also ask you a question?)”* And they said, “*Of course, of course, we are here to listen to you”.* I wasn’t there at that meeting. But he said, *“Thank you by the grace of God, you have been delivered to our village. You are looking out for us. I understand. But why are the farmers of this nation, who have been working to put food on your table, going hungry and dying of starvation and killing themselves?’*

‘According to one local medical person who was there, he said there was complete silence. “We felt like complete charlatans. We felt like idiots.” He said that guy had got to the centre of the question saying, *“Ask us this question. Why are those who put food on your table starving? Why are the children of farmers who put food on your table hungry and malnourished and sick?”* He didn’t say anything else. He said it might be a good question for you to ask us. And the doctors told us that you know, the damn thing about it is that he was right.’

Socio-Economic Determinants, Mental Illness and Suicide

‘Of course, any suicide has an element of depression. I have not known anybody who has (died by) suicide enjoy it. No, I have not known anyone who says, this is a great day to die by suicide.

‘There are two ways we can approach the issue of depression. One is still on that point, the Durkheim way of looking at the social background of that depression. Even non-medical people have learned in the last 30 years, if there is one thing all of us have learnt about health, all health, is how important the socio-economic determinants of health are. You know, it’s from 1978–80, that I begin to understand that word, reading the Alma-Ata declaration which I followed.[2]

‘Now I’m saying, you can look at the depression in two ways. You can look at the social fabric, the breakdown of community, the socio-economic cultural roots of that depression. Or you can “medicalize” the depression, that’s what they’re doing. *“Pop a pill, you need medical help for these guys. Pop a pill.”* And you know, at the same time, you’re also doing a favour to Big Pharma, right—how many millions of tablets will millions of farmers be popping.

‘So essentially, a lot of that work was done to discredit the growing evidence that the policies driving agriculture in the last 30 years have been disastrous to farmers, which is why you now have a quarter of a million of them sitting on Delhi’s borders.

‘I will give you the link to the policies and the suicide. Now you know, what you do you plot a graph of suicides, you will find that it is not even around the year. You will find three (points)—I’m telling you this, though I haven’t done it for the

last four years, I'm telling you this with complete confidence that I'm right, because I got out to report the damages. Here's what will happen—one round of suicides will occur in the pre-agricultural input purchase, around now, March—April. When you are not able to get the money to buy the inputs you require, there will be one blip there.

'The second (minor) blip will come when there's a drought and you have to re-sow and reinvest in inputs and your debt situation becomes totally unbiased. But the second major blip comes in say Vidharbha, in the pesticide-spraying issue. (I kept asking Vilasrao. I kept telling him, look at the studies in Sri Lanka, look at what is happening, I told his office.) In Sri Lanka, by the way, they banned pesticides and actually the suicides went down. And it's become a good argument also for organic agriculture in many other ways. But in several of the suicides, we found that the guy who's out in the field spraying, now he's there with all his misery, all his problems. One moment he's holding an extremely poisonous pesticide. And he thinks, let's get over with it. You will find in that spraying season, there are two kinds of pesticide deaths. One is, we use children for that a lot. With cotton, you know. And children develop cancers and other things as a result of that. The second one is, the adult doing this… It requires one moment of breakdown. One moment of, *"I can't take this anymore"*. If the thought comes at other times, the weapon is not being handled. Now, if he is standing there with that can and the sprayer? How many suicides have you read about of the body being found with a can of pesticide in the fields? Right? And it makes sense, because it shows us during that period, that person is extremely vulnerable.

‘In fact, by the way, the clinical association of clinical psychiatry, they called me. I asked them why did you call me? I’m not a pro. I’m not a mental health expert. And my own health is in a shambles now. But why did you call me? They said “*… because state governments are asking us to create modules for counselling.”* So that was where I think… they said we realize that we know nothing about their lives. So they asked me to come.

‘So you think, now the suicides figure, and this is crucial for you to get, the suicides numbers were always included in the self-employed column. Then they started breaking up columns. And saying we have further refined the self-employed category. And out of it comes tenant farmers and agricultural laborers. Where the defining characteristic of an agricultural labourer is that he or she is not in charge of his own employment! They’re roaming the country looking for work. So they are not self-employed. That’s a wrong way of understanding self-employed.

‘Now, the last thing that the media so badly covered… there are some numbers you need to know, Amrita, (when it comes to) the average national daily in this country. The Center for Media Studies and Bhaskara Rao extract some data for me on request from time to time, and we found that the front page of the average national daily on a five-year average gives 0.67% of its front page as editorial space to rural areas, or to news of rural origin. Incidentally, the 0.67% is a huge exaggeration, because it’s a five-year average. And one of those five years is election year, when you have to cover those “wretched *dehatis*” whether you like it or not, they vote. Right. So if you remove the election year,

it falls to 0.24% or less. Okay, first, 1991 to 2011; 20 years, three census. The number of full time farmers, main cultivators, fell by 15 million, as I told you…

By the way, till 1980s, until the 1991 census, the number of farmers was going up. It wasn't already in decline. It was going up. Now, when many of them went and fell into the ranks of the agrarian underclass, when many of them migrated, we never asked the question, *"Why are they leaving the countryside to come to the cities?"* because they provided us cheap labour in perpetuity. You know, when the guy gets too old, his son will come and take over as your driver, maali, whatever. So we did not ask that question, where that question could be answered in two words. Why did they come? Agrarian crisis. That is what you need to see. And there, you're looking at the largest gene pool for depression that you could possibly think of.

'Now, my own understanding is what started as a crisis in agriculture by the mid-1990s, and I'm sorry that we were slow in recognising it. The only person who called it correctly and educated us on it is Professor Utsa Patnaik, author of *The Republic of Hunger.* And she predicted a gigantic, her words were, "agrarian depression". Professor Utsa Patnaik was at that time a professor in JNU, her husband is Professor Prabhat Patnaik (also, to my mind, the most distinguished economist of this country). So she predicted that the kind of policies being unleashed are going to lead to a gigantic agrarian depression… and in some places to full-blown crisis. That's exactly what happened. You will not find the term "agrarian crisis" in the mainstream media before 2001. I take some credit for putting it there on

those pages. Then, an agriculture crisis became an agrarian crisis. When the allied occupations took a beating. By the way, the first wave of suicides after 1991 was not farmers. It was weavers, the weavers of Pochampally, of Mysore, some 71 weavers committed suicide in a year in Pochampally. You know, the famous Pochampally sari right… And when we looked at it, the first market of the weaver is the farmer and the agricultural labourer, that soft white woven cloth for the summer was soon being replaced as the industries and small industries were shut down by synthetic t-shirts from Thailand and China. Horrible for doing work in the fields, but they were, I mean, young guys were doing that anyway. And they were doing that.

‘The crisis in agriculture set fire to all the other sections of allied occupations. Then kumbhas collapsed, potters, buckets, rope-makers collapsed, all the allied professions collapsed. Then this agrarian crisis, further intensified by policies, according to me 10 years ago, it became a societal crisis, when it was affecting every other section of society, affecting urban society, with the outflow of migrants.

‘And at a time when you are creating smart cities that exclude 96% of the existing population. By then it was a societal crisis. Now I say, for the last three or four years, it is a civilisational crisis, when the largest body of smallholders in the world… Remember, the Chinese peasantry didn’t own their land. When the largest body of smallholders in the world, are fighting for their very survival, I would say that it’s a civilisational crisis, because that’s what our civilisation was about. I will also say that the agrarian crisis is not just an economic one. Today, it is a

seriously moral crisis confronting all of us. So that is the way I approach it.

'And I will end it by telling you, the suicides are not the cause of the crisis. They are its consequence. I wrote this 15 years ago—the suicides are not the cause of the crisis. They are its consequence. They are not its origin. They are its outcome. They are not the core, but they are its most tragic face. That's how I look at suicides. They are its outcome not its origin. Its consequence, not its cause.'

Mitigating the Crisis

'Let me tell you this, I think it is much easier to bring down the suicides than to end the agrarian crisis,' Sainath says. 'There are ways in which you can mitigate it somewhat. But let me put it this way. Trying to end the suicides without addressing the agrarian crisis is trying to mop the floor dry with all the taps open and running. Okay, that's what we're trying to do. Now, that still should not stop us from doing something to mitigate the numbers. It should not, if we are human beings. I tried doing it in my own small ways, knowing I'm trying to empty the ocean with a disk.

'But you can do some things. I'm saying one, we seriously need to address the problem of pesticides. Two, but before that, we need to address the socio-economic problems of the farmer. I believe and I've been calling for many years that the nature and scope of this crisis is so huge. I believe we need a special session of Parliament and of every state legislature, which will not be a token three day-two day session, but a special session of Parliament and of every

state legislature, I've written to Mr Udhav Thackeray requesting this, discussing, exclusively focused on the agrarian crisis and related issues. By related issues, I mean, land issues, I mean, the rights and entitlements of *mahila kisaan, Dalit kisaan, adivasi kisaan.*

'We are going back to the earliest part of our discussion. If you do not, if you are not willing to address the rights and entitlements of women farmers in this country, you haven't got hope of addressing the crisis. Please note that in the new agitation at Delhi's border, more and more women are showing up. In Haryana, did you ever think that women, you know from the conservative Haryanvi society, would come out in the 10s of 1000s and march towards the borders? If you do not address and engage with the issues of rights and entitlements of women farmers, the larger agrarian crisis, forget about addressing it, you have no chance.

'What will we do in that special session? The first thing is, you discuss the solutions of blueprint that has been lying 15 years in Parliament without being touched—the Swaminathan commission.

'Instead you put a bunch of four people, one of whom resigns before the first committee meeting. And you think that they are going to produce a scholarship of the eminence of a Swaminathan? And this, by the way, when Supreme Court gives them two months to come up with solutions. You know, when I was asked to be a member of the committee, I said, *"Hey, I will get on to a committee if you have a committee for speedy implementation of the Swaminathan."* What am I going to do in two months that will better work? And that, that Commission's work, which is actually the

National Commission for farmers, was based on massive consultation. That's why every farmer in the country, whether in Yavatmal or in Kochi, if they know two words of English, they know the Swaminathan report, lagu kar. They know what it says on industry. They know what it says on issues important to them. We need to discuss that report in Parliament and in every assembly.

'Second: We need to discuss the related issues like land reform, women's rights. Poor Swaminathan, his report has lain there since 2004 December. The first report 2004, last report 2006, not one day's discussion. (But we could call a special session at four days' notice for GST… We passed the GST when it comes to a corporate requirement, we passed the GST bill in four hours. It became an Act.) For 15 years the Swaminathan Report has been in Parliament, you have not had one day's dedicated discussion. Not one day. I'm saying I demand a special session. And it will look at deprivation, it will look at the related issues, women's rights, adivasi rights, dalit rights.

'The next thing that you have to do: There are many things, we have to declare that farming is a corporate-free zone. We have to understand that farming is a livelihood. That farming in any society is the newest, lowest wage sector. And we have to compensate them for it, people who continue in that profession. Basically, it boils down to this question, do you want community-led farming or corporate-led? If you answer that question, you've got the answer to your question.

'There are many things to do, which can go forward. I am grateful to the other governments of the country I'm talking to, I will be writing to Stalin. I don't know him well

personally, but we know of each other. And I have sent it to the Congress Chief Ministers saying and to (Maharashtra Chief Minister) Uddhav Thackeray, saying let's call a for the repeal of the farm laws. But please understand one thing—repealing the farm laws, takes you back to where you were, it doesn't take you back to a nice place. Repealing the farm laws is agreeing not to torture the wounded body further. That's all it is. The new farm laws are an acute aggravation of the economic crisis. They are not the crisis. It's saying that okay, I want to rub salt into your wounds. That, that is the thing of it. Repeal the farm laws.

'Second: I'm talking about immediate, call for the special session of Parliament and Assembly.

'Third, say that every district, every taluka, wherever you can, launch a *kisaan bachao desh bachao* committee, food is everyone's concern, and let these committees monitor the working of APMC and pricing and MSP. I'm talking about 1000s of committees where locals get very involved in this. I'm saying that all of us in the middle classes should start CSAs in our localities, which is Community Supported Agriculture. Now I have advised LIC which has more than a thousand offices, I said why don't you take a pledge that every canteen you have, you will only access and buy food from farmers within a 150 kilometer or 100 mile radius. Then you're going to get fresh food. You can then dictate to the farmer, no pesticides, no poisons. I managed actually to get this done into colleges in Minnesota, but not here. Okay. (The LIC union is for it. But they are fighting for their survival.)

‘I’m saying that this is the way to go forward— Community Supported Agriculture. Now, I’m saying all school midday meals don’t have centralised staff. Look at Thane, the district of Thane, all adivasi kids. First of all, these kids—let alone your biscuit mix crap, they are not even rice and wheat eaters. They eat their own rich cereals. I’m saying that these self-help groups should be sourcing their material, not from a centralised pool but from the local farms, which has happened in some states.

‘… But I think it’s something to be fought for and done. And I’m saying the farmers at Delhi’s borders are fighting for all of us.

Do People Care?

‘I would say a lot of people are concerned when they get to know, a lot of people don’t really understand what’s going on. A lot of people are concerned. I know that because I talk about this campaign 365 days a year. I see, I see that the way it is put across to people matters a lot. How does the media put that across? *Times* started publishing articles from district collectors showing the rise in alcohol sales in their district. You make the farmers look like parasites. But apart from that, when it is put to them properly, when you make people understand what it is, I find that there are grown adults, men included in the audience who are in tears.’

The farmer suicides touches a constituency, which, see anybody who’s got a stomach is connected to a farm. Okay, that is one. Second. And that reminds me of another thing.

More women have committed suicide than farmers. Are these mutually exclusive categories? Okay, so you're saying this is a very misogynistic approach. You're saying women can't be farmers and farmers can't be women. You do not compare an occupation and the gender. You compare occupation with like occupation. And you compare their relative population base. Anyway. So the government's approach, remember this. "Farmer suicides look bad in the Western media." We are primarily concerned with how we appear in the white man's eyes as governments.'

LESSONS FROM THE NEIGHBOURHOOD: SRI LANKA'S STORY

In conversation with Duleeka Knipe

Sri Lanka is one country that has made giant strides in reducing its suicide rates—by implementing what experts believe to be a fairly simple intervention, that of restricting access to pesticides. We speak to Duleeka Knipe, an epidemiologist who has worked on the public health trial looking at introducing locked pesticide storage boxes to households, to try and reduce the incidence of pesticide-related self-poisoning in Sri Lanka. Edited excerpts of our interview:

Q:What is it about this work that keeps you going—what is it that keeps your interest piqued?

Duleeka: 'When I first came into this field, I always had this idea that suicide was something that people did when they had a mental health problem like a mental disorder. So, essentially only a very small portion of the population should end up engaging in this behavior. And that's kind of from my understanding, some of the teachings that I had from my Master's and some experience with suicide-but the reality was, once I was working in Sri Lanka, and hearing people's stories, suicide was, to me, not associated with a mental disorder. It was more social factors, and the social environment. And that sort of really piqued my interest in this because it was obviously factors

that are not easy, but possible to modify, and would alleviate a lot of distress in the communities that I work in.

‘For example, migration plays a role in suicide risk and mental stress in Sri Lanka, and in lots of South Asian countries. Mothers and fathers migrating on short term contracts abroad for low wage labour may have an increased risk of suicide during their migration. The ‘push’ factors for the migration, for example, poverty, abuse, may be the reasons for heightened risk. That and migration may also impact on risk in household members ‘left behind’. Additionally, when they (the migrant worker) come back, the migratory experience has forever changed that family. So there’s lots of things that are, I think, specific that’s going on in these contexts that have not really been understood in the past.

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‘Primarily, a lot of the evidence that’s out there often comes from settings where maybe mental disorders are really strong predisposing factors for suicide, mainly high income countries- in contexts like Sri Lanka, that doesn’t play out so well.

‘We don’t find this association to the same degree in Sri Lanka. But that’s not to say that mental disorder isn’t on the causal path, you know, social factors can obviously lead people to develop mental health issues that then lead to suicide. But I think for me the focus when I have talked to clinicians who have worked in Sri Lanka, but also not just clinicians, policymakers too, there has been this focus on just mental disorders. Clearly you need to identify and treat mental disorders, but for me, you know, you can treat somebody for depression and anxiety but if they are living in a household with extreme violence, what are you doing then? That’s not necessarily going to reduce their risk of suicide, or self harm, in my opinion. So I guess it’s about challenging that assumption that suicide only happens against a backdrop of mental disroders, and trying to shift and change the lens a little bit to refocus on social determinants as well as clinical factors.’

Q: What implications do you think that has for any interventions that we develop for reducing the rates of suicide? Because the focus, I mean, at least in India, as well, just as you described in Sri Lanka, is on healthcare interventions, because you’re looking at suicide as an outcome of mental health problems. So what implications do you think this kind of different

understanding of suicides as an outcome of a range of social determinants would work out?

Duleeka: 'It requires a multi-agency, multidisciplinary and, multi-ministerial, policymaking kind of a response. This isn't a problem, or an issue that's unique to the Ministry of Health or the health personnel in the country. This is something that spans across so many different disciplines. And, there needs to be a more concentrated, coherent response to that as well. So from my work in Sri Lanka, one of the things that I did was talk to the ministries and find out what they're all doing, , because there is a recognition that suicide—especially in Sri Lanka, (which) had one of the highest suicide rates in the world—is something that is very readily talked about. And people are aware that it's an issue. The Education Ministry, the Women's and Child Health Ministry, or Well-Being Ministry, Economic Ministry, you know, all of them understand that this is an issue, and they all have things that they're doing, but they're not connected. And that's where I think it falls apart; any intervention needs to be a complex, multi-component intervention, that requires a more integrated approach. How do we get there? I think it's going to be a challenge. But maybe this sort of shift away from thinking of suicide as purely a health issue might help.

Q: If you were in a position, let's say, to make recommendations to the government of Sri Lanka, on what needs to be done, what are the key recommendations that you'd make in order to prevent suicide?

Duleeka: 'The first is, you know, understanding the sort of local problem, a local issue and understanding what methods people use for suicide, because I think that's kind of the starting point. And making sure that main public health measures that can be implemented are implemented. So, for example, in Sri Lanka, you know, pesticide suicide deaths was a huge issue. So an implementation of national bans on toxic pesticides that don't have an impact on agricultural and economic output, but can save lives is the first start because you can't support people who have already died by suicide—this is the starting point.

'But going from there, and that's where Sri Lanka is at the moment. What Sri Lanka needs to do, in terms of priority setting is, is to implement a task force—a group that perhaps talks to each other and takes ownership of the issue from different sectors. And this has to be a widespread kind of group that includes the mental health stakeholders, but also education and economics, as well as the charity sector. Having a suicide prevention strategy

is something that needs to happen. Sri Lanka is currently developing theirs, but the actual nitty gritty hasn't been ironed out yet.

'The other thing that I would say is not just having this group, but this group also needs to recognize that any intervention has to be at different levels. So you kind of have to have interventions or approaches at the public health or at the national level, but, you know, looking also at the institutional level, but then communities as well. So having that sort of multilevel approach to suicide prevention, in my opinion, would be a good way forward.

'And from my understanding of domestic violence, and things like that—things that haven't really been talked about in any great detail from a suicide prevention perspective; needs to be part of these higher order discussions.

'I guess the other thing, which I have spoken to people about, is about problem solving skills, and changing the… social norms around how you deal with difficult situations, especially for young people. Because it's become so normalised, something that supports those young people in developing strategies that don't lead them to attempt self-harm or die by suicide, you know, thinking about other tools that they might be able to develop? Yeah, I think that's it, there's loads obviously, I could keep going on forever…'

Q: As an objective observer now, to me, it feels like okay, these solutions that Duleeka has given are pretty straightforward. And if the policymakers set their mind to it, would they be able to do that? Especially considering the fact that there is no argument on whether this is a big public health problem or not. We all agreed on that policymakers acknowledge it. So that's not really an issue. So what do you think are the key challenges or barriers which stop this from happening?

Duleeka: 'Yeah, I think there are a couple of things that sort of, I suppose spring to mind. One of them, I think, is that there is this idea that it's inevitable sometimes, you know, that you can't stop them. *If they want to do it, they'll go do it.* They're going to die by suicide, they're going to take an attempt on their life. And there's a little bit of fatalism around that. And, and I think that needs to shift, desperately needs to shift because we're not going to get anywhere if that is what people think. Because it's simply not true.

'You know, most people who think about suicide have transient thoughts. We know that once someone attempts to take their own life, they are not likely to attempt again, especially in Sri Lanka. So if there is a moment in which

you could intervene and stop that person, we should be doing that. I don't think it's an inevitable event. Its not inevitable that somebody will die by suicide and we need to move away from that fatalistic approach.

'The other thing I think that sometimes is very difficult to challenge is that, you know, when you're talking about policy-making, these things often take time to develop. And governments change. People change in the policy lead positions. This has happened to me—I've worked with somebody for a long time in developing something, and then they move into another part of the government, and then it sort of loses momentum. And sometimes that's quite a challenge. And that's kind of, I guess, a structural challenge more than anything else.

'So there is that sort of political issue, in trying to keep that momentum going. And I guess the other thing is that the way things are structured, often these sort of silo approaches are something that are often easy to manage. Something that's kind of cross-cutting is difficult to manage, it's difficult to lead. I'm not really sure exactly how we achieve, better coherence across these siloed approaches. But as I said, that I think good leadership is something that is needed, but also consistent good leadership over a longer period of time. It's not something that can happen in, you know, a couple of years, this is something that needs buy in for a longer period of time. So I think that for me, those are the kind of challenges in implementing anything like what I'm suggesting.'

Q: Did you then notice a change over the years in how these challenges present, I mean has it become easier now to communicate with policymakers, or does it remain the same? Or has it gotten more difficult? And as you become more experienced, and as you've kind of, become more of a familiar face within that context, have things changed? Or even kind of generally, has there been a change in the context or the narrative within the country, which has made some of these conversations easier or more difficult or do things remain the same?

Duleeka: 'From a personal perspective, yes. I think just having engaged with people and as you say, becoming somebody people recognise has been really useful and important… I guess it's like a key informant kind of thing. I guess for policymakers, they sort of come for information and all that, you know, I provide them with reports and things that they don't otherwise have access to. So, that relationship has got easier; the communication pathways have opened up to allow for direct engagement, which is great.

‘And also I think in Sri Lanka you know, there has been a bit of focus on suicide and self-harm over the years, because of the fact that Sri Lanka had this high suicide rate. More and more people recognise that actually Sri Lanka has made massive reductions in their suicide rates, because of the implementation of a very simple public health intervention (banning toxic pesticides)—the suicide rates have come down. But self-harm attempts have gone up, and people kind of have engaged with that. And when I say people, I don’t mean just the psychiatrists who obviously are at the moment leaders in suicide prevention in the country, but also NGOs and other organisations. It’s kind of come up higher on their agenda. Because more people have attempted and have survived their attempt, the population with lived experience has grown. This has helped with the conversation in Sri Lanka. And so yes, I think… I think things have become easier in Sri Lanka, because the lived experience voice has basically become louder.’

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Q: And if we were to expand the scope of, the geographical scope of this slightly, what lessons do you think other low and middle income countries that are struggling with similar problems, for example, India, what are the lessons that could be learned from your experience of what happens… what happened and what happens in Sri Lanka?

Duleeka: ‘Well, I guess, for me, this pesticide suicide story is one that I think is a lesson that can be translated quite easily because this is about means restriction. So I think from an Indian perspective, and you know, implementing some of these bans, focusing at national level, rather than going down to the individual, is something that would make inroads into reducing the suicide rate in India and I know that there’s been some implementation of some bans recently.

‘I haven’t thought in great detail, because COVID has taken over my life. But I understand that there has been some implementations of some bans. So it’ll be interesting, now, definitely to see how that has impacted India’s suicide rates. That I think is something that they can sort of take from Sri Lanka. But you know, Sri Lanka is not a… (laughs) not the sort of shining light in this, it’s just that Sri Lanka has reduced their suicide rate. But we’ve got, you know, a real significant problem with loads of people still attempting suicide, and engaging in self-harming behaviour. So it’s just… it’s shifted the problem, not shifted, but saved lives. But there is still a significant issue that we need to work on—people are still engaging in self-harming behaviour to a great

degree. But the starting place is to stop people dying and so I think that is what countries like India need to do—they need to implement the public health measures that have worked in Sri Lanka, simply put ban highly toxic pesticides.

Q: Anything else that you think is important and kind of needs to be followed?

Duleeka: I guess… this is just something that I've noticed in Sri Lanka and I don't know if it's quite the same in India, but you know, we talk a lot about media reporting, and making sure that the media, take a sort of a more prominent role in preventing suicide by responsible reporting, and I think that's definitely something that still needs a lot more work in Sri Lanka.

There is a culture, I think, and this stems, probably, from the sort of history of Sri Lanka being a conflict area, that people are quite used to seeing quite gory images, in the newspapers, you know. Sri Lanka's past having had experienced a tsunami and that sort of thing, that there's the equal gory sort of detailed description of suicide in papers, and especially in the non-English papers. This obviously has an impact, because we know from evidence elsewhere, that this does have an impact on suicide rates. So, I think there's a kind of an important role that the media has to play here that I don't think at the moment it plays, especially not in Sri Lanka.

But also one phenomena that I have noticed and I've shared actually on my social media accounts… it's not just the media, it's in social media—people are sharing stories, videos of people attempting suicide; they're sharing graphic details, which obviously, is problematic in terms of suicide prevention. It's an area that we haven't really got to grips with in terms of how to tackle that. But I know that colleagues in Australia have started to develop something— it's called *chat safe,* which basically has some sort of guidance on social media use, and responsible social media use by the general public, in trying to prevent suicide. And I think that's something that, you know, is still in its infancy, but something I think has a real potential impact.

CHAPTER EIGHT

SUICIDE AND THE MEDIA

Amrita Tripathi

My first job was as an intern at a radio channel, one blistering, confusing summer—that infernal gap between high school and college where you think you're older, smarter than people think you are, or maybe it is the other way around! Either way, I was all confusion, unsure of myself, in a new city, at the cusp of young adulthood, and my first boss was everything you could hope for—smart, witty, grounded, and with a keen eye that missed nothing. I'll always remember him as a force of nature.

He's also the first person I know of who died by suicide. Reasons unknown and unknowable. It gave me my first inkling of the unfathomable side of everyday life, and how things are not easily resolved into neat categories that make sense.

⁂

I've been on different sides of that line that masks the unfathomable—I remember writing as a health editor to someone after reading their excoriating take on the UK media coverage of the death by suicide of Sylvia Plath's son. I equally remember anchoring the news around the death of 25-year-old actor Jiah Khan, and the media circus that it became. This past year, I've watched and cringed at the

media ‘tamasha’ around the death by suicide of 34-year-old actor Sushant Singh Rajput, and along the way have learned of and spoken about the importance of reporting responsibly on suicide.

Long before the Press Council of India’s guidelines issued in 2019, I had shared well-regarded Suicide Prevention guidelines with an entire newsroom I worked in as a best practice, and while a senior editor appreciated the fact that I had sent them and emphasised that these could help us save lives—I was not being hyperbolic— bemoaned the fact that it was hard enough to get news desks and editors to follow other guidelines that were ‘legally enforceable’.

It’s well past time for the media and individual journalists to learn that they are critical stakeholders when it comes to suicide prevention. The main issue? Possibly that no one has told the journalists. The way things stand today, you might not actually be aware that there are well-established guidelines on reporting about suicide. Reporters and editors reading this, know that you can literally save lives based on how you choose to report. If this is news to you and many journalists (no judgement here), this may be because it’s not something that is top of mind for the mainstream media in India—possibly because the fundamentals of journalism have long been held to be along the lines of ‘If it bleeds, it leads’. But you should know that guidelines have been shared by the World Health Organisation, the Samaritans, and closer home, even by the Press Council of India, for reporters not to sensationalise suicide reporting, and with good reason.

Why Is It Important?

Let’s equip ourselves with some of the basics when it comes to a phenomenon known as ‘suicide contagion’ or ‘copycat suicides’. There is well-documented global research showing that copycat suicides are influenced by popular media—this is called the *Werther effect*, after a novel written by Goethe.

‘In 1774, Goethe published the novel *The Sorrows of Young Werther*, in which the protagonist, Werther, kills himself out of unrequited love. The novel is said to have triggered a wave of suicides in Europe. In 1991, American novelist and euthanasia activist Derek Humphry published *Final Exit*, laying out several methods of suicide. The book, a *New York Times* bestseller, stirred immediate controversy since critics feared it could nudge even those not terminally ill to commit suicide,’ journalist Tanmoy Goswami writes in The Health Collective.[1]

Dr Lakshmi Vijayakumar, who founded India’s first suicide intervention centre, Sneha, back in 1986, says there is ample research to suggest that the Werther effect is a tragic reality. ‘Now we have enough research to show that particularly for a celebrity suicide, there is an increase by 10% to 30% suicides,’ she says. ‘For example, the Hollywood suicide of Robin Williams—following that there has been a 13–14% increase in suicides among middle-aged men using the same method.’

Now, if you’ve noticed anything about reporting on suicides in the mainstream media in India, it is that there is near-apathy most days, which hyperventilates into a near-hysteria when there’s a celebrity involved (think Kurt Cobain, Chester Bennington, and closer home, Jiah Khan, Sushant Singh Rajput). As of 2021, the news of the tragic death of 17-

year-old wrestler Ritika Phogat was making headlines, with news reports speculating that she took the extreme step after losing a tournament. This is not helpful but follows a predictable and depressing pattern of speculating and over-simplifying, which can have tragic fall-out. Scapegoating, speculating and simplifying a multi-factorial and tragic decision helps no one. But we've been here before. Perhaps nothing has come close to the media frenzy around the tragic death of young actor Sushant Singh Rajput in the summer of 2020. People reported feeling triggered, not just extremely uncomfortable with the feeding frenzy, and it has led to catastrophic results.

'Following Sushant Singh Rajput's suicide, Greg Armstrong, who is a researcher in Australia and myself, we did a research study[2] on the Google search trends. And we found that there was a substantial increase in the number of people searching for how to do suicide, how to die by suicide, and also a reasonable amount of inquiries on how, where can we get help for suicidal (ideation),' Dr Vijayakumar says.

Key highlights from Armstrong et al (2021) Report

- The study assessed how the public responded to Sushant Singh Rajput's death by suicide in June 2020, in terms of online search behaviours.
- The study examined changes in internet search queries in India in the three weeks following the suicide, compared to the two preceding years.

- Researchers were curious about both the Werther effect (suicides can be a stimulus for subsequent imitation suicides) as well as the Papageno effect (media reporting can stimulate protective effects on suicide). Both these effects have been highlighted in previous research studies.
- At Week 1, researchers observed large relative risk (RR) increases for ‘suicide’, ‘commit suicide’, ‘how to suicide’, ‘hanging’, ‘how to hang’, ‘suicide hanging’, ‘aatmahatya’, and ‘khudkushi’. This persisted at week 2 as well.
- At Week 1, they also observed large increases for the putatively protective search terms ‘suicide prevention’, ‘suicide helpline’, ‘depression’, ‘depression doctor’, ‘psychiatrist’, ‘antidepressants’, and ‘avsaad’. This also persisted into week 2.
- Thus, Sushant Singh Rajput’s death and the large-scale media reporting appears to have activated large increases in both harmful and protective Google search queries in India. Whether this actually led to an increase in suicides can only be seen once this data becomes available, however, this study has shown the importance of promoting media guidelines in suicide reporting.

Which means, that essentially every time there is (what feels like) a feeding frenzy on air with all the breathless commentary and gory details on our TV (or social media) screens, it’s putting vulnerable people at further risk. This is why global organisations like the World Health Organisation (WHO), Samaritans, and many others have clear guidelines for reporting on suicide. (More on these below.)

There’s a recent paper[3] calling for urgent attention, citing multiple media reports on an uptick in celebrity suicides during Covid-19 in India.

‘Celebrity suicide itself is a risk factor for suicidal ideation and suicide attempts both in short term and long term among general public. The recent increase in the suicide rate among celebrities is alarming and needs immediate attention from researchers, mental health professionals, public health professionals, and policymakers, especially in India. Sigma related to mental health, complex coping mechanisms, frustrations, unemployment, and mistrust among celebrities need to be explored and addressed. Interventions directed towards the mental health of celebrities or famous personalities will help to reduce the glamorization of suicide or mental health

issues, sensitive media reporting, and epidemic of copycat suicides in the community.

Immediate action is warranted involving all the stakeholders for suicide prevention to come forward and take necessary actions to prevent it. Responsible media reporting should be implemented to minimize the effect on the general population and one recent pilot study found the reporting irresponsible.'

Guidelines As a Guiding Light

What would responsible media reporting look like? Back in 2008, the World Health Organisation published 'Preventing Suicide: A Resources for Media Professionals'. To quote from it:

Quick reference for media professionals[4]

- Take the opportunity to educate the public about suicide
- Avoid language which sensationalizes or normalizes suicide, or presents it as a solution to problems
- Avoid prominent placement and undue repetition of stories about suicide
- Avoid explicit description of the method used in a completed or attempted suicide
- Avoid providing detailed information about the site of a completed or attempted suicide
- Word headlines carefully
- Exercise caution in using photographs or video footage
- Take particular care in reporting celebrity suicides
- Show due consideration for people bereaved by suicide
- Provide information about where to seek help

- Recognise that media professionals themselves may be affected by stories about suicide

More recently, here in India, The Press Council of India based their guidelines on the widely regarded WHO guidelines. To quote from a key paper by Vijayakumar, 'Media Matters in Suicide: Indian Guidelines on Suicide Reporting' in the Indian Journal of Psychiatry:[5]

'The Press Council of India chaired by Justice C.K. Prasad, in a release dated September 13, 2019, has adopted guidelines on reporting on suicides, based on the WHO guidelines. It states that newspaper and news agencies while reporting the cases of suicide must NOT:

- Place stories about suicide prominently and unduly repeat such stories
- Use language which sensationalizes or normalizes suicide or presents it as a constructive solution to problems
- Explicitly describe the method used
- Provide details about the site/location
- Use sensational headlines
- Use photographs, video footage, or social media links'

A key challenge though lies—again—in implementation. In the absence of legally binding guidelines, is there a need for self-regulation of and by the media?

What's Wrong with the Media Reporting on Suicide

Evaluating the Reporting

An analysis by Dr Pathare and colleagues of English media reports in India indicated an increase in online media reports of suicide and attempted suicide during the Covid-19 lockdown (2020), according to a study published in the International Journal of Mental Health Systems.[6] The study found: 'There were online news media reports of 369 cases of suicides and attempted suicides during COVID lockdown vs 220 reports in 2019, a 67.7% increase in online news media reports of suicidal behaviour.'

Dr Pathare shares, 'We do not know if this indicates an actual rise in suicides during the Covid pandemic as only about 1–2% of suicides daily get reported in the media. However, the increased reporting increases the risk of inappropriate reporting and potentially leading to more suicides.'

The study—which mentions that one of the limitations is the scope being restricted to English news media, as well as the fact that only a 'small fraction' of suicides (estimated at 300–500 per day) are reported about— found that in 2020, '…news reports of 128 suicide cases and 29 attempted cases (Total = 157) mentioned fear of COVID, lockdown and/or the person was quarantined as a cause for suicide/attempted suicide.'

Also of note: 'There were significant regional differences in suicide reports between the two years. Bihar showed the highest increase (seven times) in news reports of suicide during the lockdown as compared to 2019.

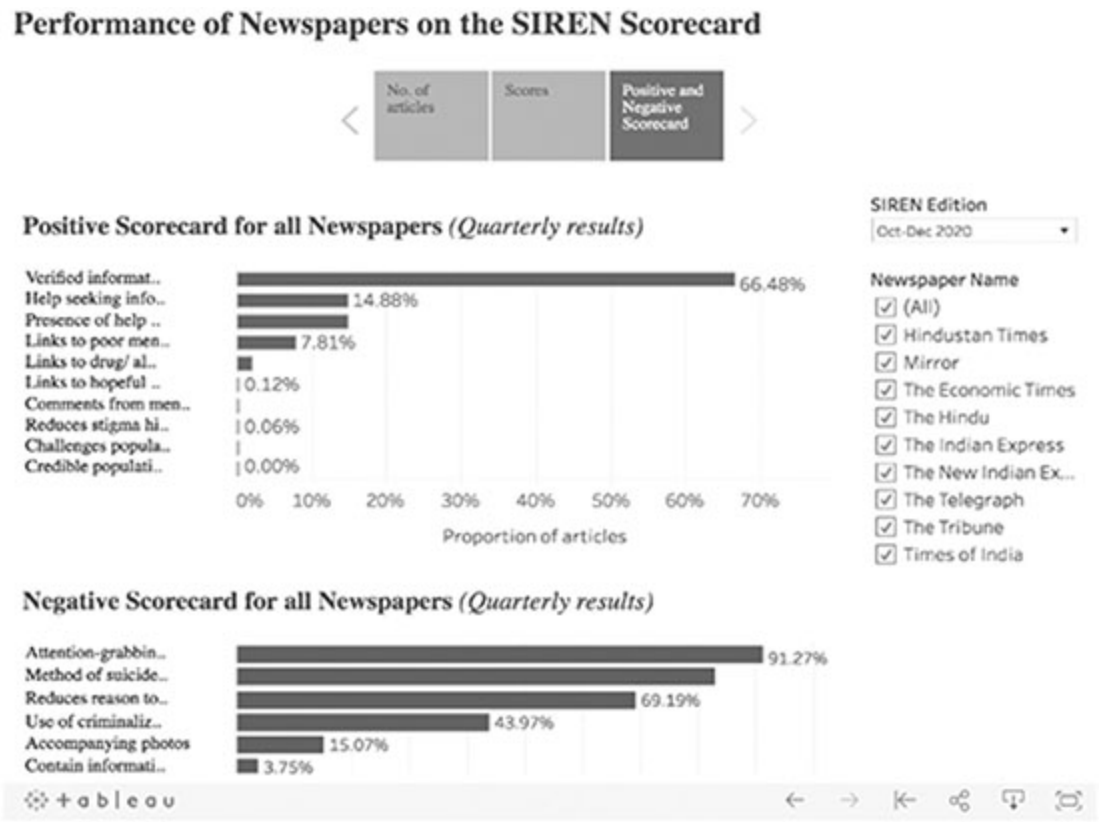
'Southern states, namely Telangana and Tamil Nadu, showed an increase in news reports of suicides between (2.6

—50%) whereas in Kerala reports increased four times, Karnataka increased 2.5 times, while Andhra Pradesh and Puducherry showed reduced news reports of suicides.'

Whether the media decide to follow guidelines remains to be seen.

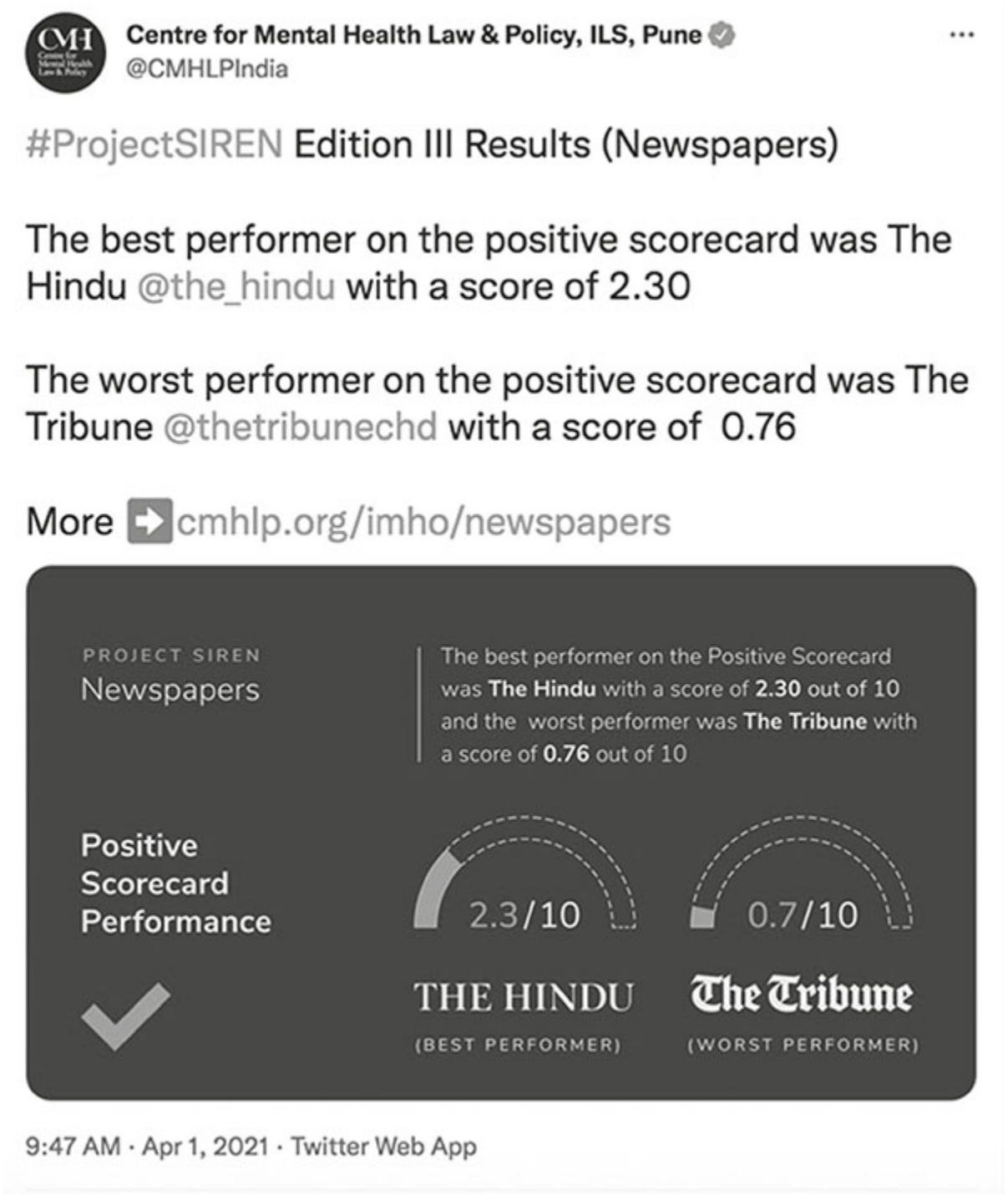
The Centre for Mental Health Law and Policy Project SIREN analyses newspaper reporting on suicide, assessing the reporting by various parameters to create a suicide-reporting scorecard. (More on the methodology here.)[7]

To quote from their site, 'In the most recent edition of SIREN, Edition III, we evaluated articles from eight of the highest read English-language newspapers in the country. Between October 1–December 31, 2020, we found 1,626 articles on suicide and attempted suicide. The results for the quarter, as well as the previous two quarters, are indicated on the opposite page.'



(Image retrieved 4 April 2021)

And to share a Tweet from their Twitter handle from April 1, 2021:

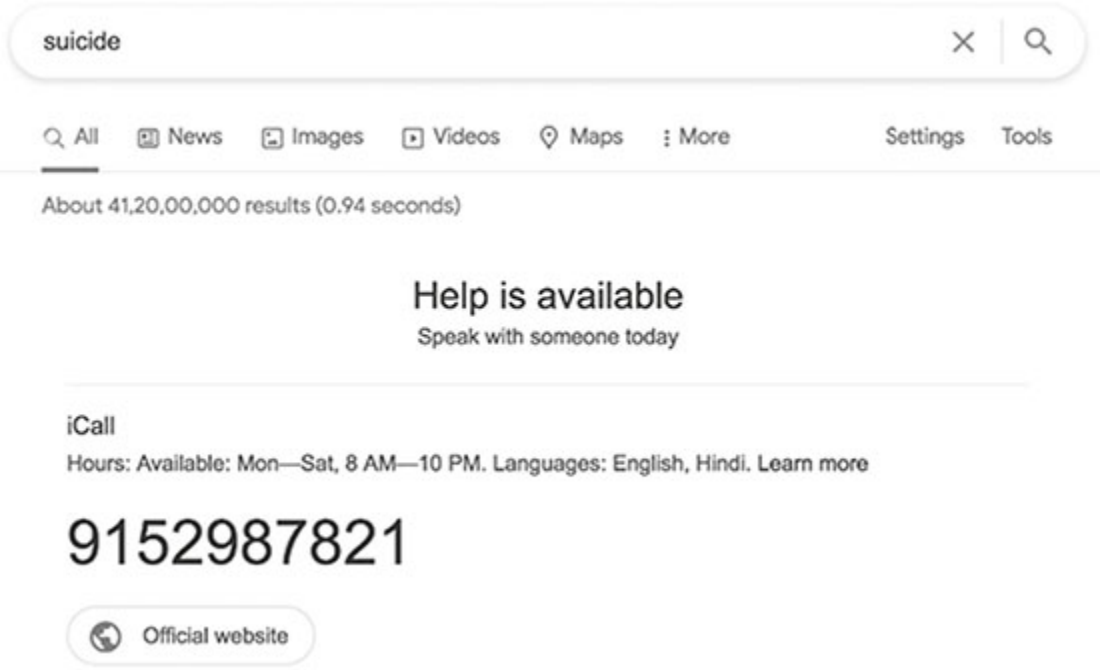

Centre for Mental Health Law & Policy, ILS, Pune
@CMHLPIndia
#ProjectSIREN Edition III Results (Newspapers)
The best performer on the positive scorecard was The Hindu @the_hindu with a score of 2.30
The worst performer on the positive scorecard was The Tribune @thetribunechd with a score of 0.76
More cmhlp.org/imho/newspapers
PROJECT SIREN
Newspapers
The best performer on the Positive Scorecard was The Hindu with a score of 2.30 out of 10 and the worst performer was The Tribune with a score of 0.76 out of 10
Positive Scorecard Performance
2.3/10
0.7/10
THE HINDU
(BEST PERFORMER)
The Tribune
(WORST PERFORMER)
9:47 AM · Apr 1, 2021 · Twitter Web App

Searching for Credible Information

Apart from the media as a source of trusted information, the ubiquity of mobile phones and cheap data in India have revolutionised access to information. That makes the use of online search toolbars a critical potential intervention point. And make no mistake, this is not a problem that is only faced by ‘other’ people, people who are ‘not like us’ (as you will have gathered through the chapters till now).

The Singapore-based company Quilt.AI, co-founder Angad Chowdhry and team shared a study they did on what Indians have been searching for online when it comes to Mental Health. They shared their results in late 2020. ‘The most startling and distressing finding was the sheer volume and scale of the problem—11 million yearly searches on anxiety; 267,000 help-seeking searches every month. There was a 52% growth in searches in a year and the most worrying was an 82% increase in searches on suicide. This data signals a desperate call for help…’ Dr Chowdhry told The Health Collective in early 2021.

So what do you find when you search ‘suicide’ say in a search engine like Google? Platforms will automate prompts to direct you to helplines.



(Image retrieved 4 April 2021 via the link: https://cmhlp.org/imho-siren/newspapers/)

Dr Chowdhry told the Health Collective[8] that there is a need for more robust collaboration. 'Search is a key intervention point—people rarely talk about suicide or their own challenges on mental health but they do search about it. Though some social media platforms are taking steps to provide or redirect people to resources; this redirection to resources should be available when people first start searching about suicide or mental health issues,' he shares.

(Editor's Note: Do reach out to a professional if you or someone you know feels distressed and talks about ending it all. A link to helplines is listed at the end of this chapter.)

It's important to note that citing helplines or where people can access help is one of the best practices when it comes to

reporting on suicide, and more media organisations need to be aware of this (and now that so many of us share news on social media, it goes for each one of us). It all has to come together, given the dominance of digital media and access to information, and it needs to be credible, across all languages we search in, not just English.

Who Reports on Suicide?

One critical factor in how journalists cover suicide in India has to do with the fact that till very recently, attempted suicide was a crime. Section 309 of the Indian Penal Code criminalizes attempted suicide[9]—though the landmark Mental Healthcare Act of 2017 decriminalises it and says it's the duty of the government to provide the individual care, treatment and rehabilitation. Having said that, there is still a gap when it comes to implementation, with media reports and stakeholders suggesting that a lot remains to be done.[10]

As a result of this—and despite the Mental Healthcare Act's provisions—if there is such a 'beat' as suicide, or reporting on suicide, it is usually given to crime reporters in most news organisations.

Veteran journalist and Executive Editor, *Hindustan Times*, Sachin Kalbag, who has been a journalist for 27 years, tells us this may be the 'single biggest problem' when it comes to the media coverage, as it has a strong impact on the tone and tenor of the reporting. 'Because traditionally, attempt to suicide was a punishable offense and suicide was always recorded with the police, the crime reporter got the news first. I think the single biggest change that editors across

India can bring about is to make the coverage, rather to give the coverage of any suicide, (if at all, it's important for the public good) to health reporters, people who have more access to the medical profession, people who have more empathy towards understanding what the medical issues or the health issues are for a particular person. This is something that we are changing slowly but surely, at least in the paper that I work with.'

Incidentally, with the Indian news industry in the grip of financial insecurity, triggering a wave of lay-offs and restructuring, there are fewer health editors and health beat reporters than ever—many newsrooms have moved away from the specialist to generalist model of reporting. But things may be changing… Much like the recent H5N1 (bird flu) and H1N1 (swine flu) crises, where health reporters and editors were in high demand and given ample air time and column space, the SARS-CoV-2 virus has ensured health, healthcare and even mental health are top of mind, via regular news bulletins. This is a welcome change, given how long health was seen as a 'softer beat' in the mainstream media meant for cub reporters who would eventually be promoted out of it, after putting in the hard yards. (Anecdotally, reporters who would cover the Health Ministry (MoHFW) would have the 'hard' or political beat, while health was relegated to the features section.) Cut to 2021, when everyone is scrambling to understand clinical trials, adverse effects due to immunization (AEFI), the difference between multiple vaccines and the R-numbers, and even anxiety and mental health, due to the fall-out of this global crisis.

Given that layered context and what it's exposed in terms of gaps in information-gathering, perhaps it won't be seen as so unreasonable for senior editors to make the call to assign more prioritization to the health and mental health beat.

How Are We Reporting—What is the Narrative?

When you look at recent headlines on suicide, it's either celebrity-dominated or dismal and statistic-led, usually around Suicide Prevention Day.

It's easy to presume that journalists are cynical, world-weary and don't care about the tragic loss of life of each individual suicide, and that their reporting reflects that. But that's usually not the case—ask any TV or print or digital reporter, and they would just as rather have a 'human face' to most stories as the cold, hard statistics.

It's also not true that people don't care. Senior journalist and the founder of the People's Archive of Rural India, P. Sainath says, 'People do care when they know. The way it's put across,' is critical, he says, and he would know.

Sainath has been instrumental in drawing the country's attention to the farmer suicide crisis, through rigorous and data-backed reporting, starting with stories that appeared in *The Hindu*'s *Frontline* in 2007, with data interpreted by Dr K. Nagaraj, and work by M.L. Narasimha Reddy, when the duo cottoned on to the huge mismatch between farmer suicides misclassified as 'accidental deaths'. At a time when there were schemes for free pesticides, and famers were choosing it as a method of suicide, whose tragic deaths were being reported as accidental deaths due to 'stomach ache'.

Though Sainath says we will never know the true scale of the farmer suicide crisis, there's no doubt that what we do know is in no small part thanks to the rigorous and humane reporting he has been at the forefront of for more than 12 years. That's the power of journalism done right. Even if having visited 'over 900 families' of farmers who have died by suicide means Sainath has destroyed his own health, as he shares.

Sandhya Menon, a Bengaluru-based independent journalist and mental health activist who speaks openly about living with depression and bipolar disorder shared in 2020 that she had dealt with suicidal ideation; writing a piece on explaining this phase to her two young children. She chose not to shut down the conversation when her kids asked why and how she featured as a 'suicide survivor' on a media panel, she tells us, instead explaining to them some of what she was going through. Her own parents were not comfortable with the conversation or topic, despite being strong champions of her and supporting her through her own journey.

Menon's advice to her own fraternity in the media sounds simple to implement. *First, stop reporting on suicide only when there's a celebrity involved.* It 'boggles the mind' that more media outlets, both in English and non-English languages don't have a dedicated space to talk about mental health and illness, she says. 'Let's just start reporting on this stuff. And not in terms of statistics, right?' she says, adding that hearing that 'XXX number of students died by suicide' doesn't have the same impact on readers as actually hearing from somebody who is a survivor of suicide loss.

‘Find somebody who has lost a relative. And there are so many people who want to speak, because they don’t want other families to go through what their family has gone through… Talk to somebody who’s, who tried to kill themselves,’ she says.

‘And let’s not leave that conversation to experts… That’s the other thing. You have a suicide and then you have, like five doctors giving their opinions. The reports have to be led by people who have been there.’

That’s the only way to help improve the coverage and help the information become more accessible. ‘When you ask me what’s lacking I mean my god, what is not lacking?’ she adds, including that the main issue with ‘expert-led’ interviews is that there is so much jargon, which may not help reach the folks who need to hear the information the most. ‘They talk the jargon that people in the medical sphere will understand but a 14-year-old who wants to, you know, end it all, a psychiatrist’s quote is not going to help. What will help is an 18-year-old saying, you know what, when I was writing my board exams, I failed, and I tried to kill myself, but this is what helped me. Imagine a 15-year-old going into an examination, reading something like this, it’s going to make a world of a difference. So I think that’s the fact that we don’t give it space.’

A sobering note, and one borne out by conversations I have had with media persons is what Menon adds, that this is personal for all of us, including journalists. ‘It’s not like journalists don’t know people who are mentally ill (sic) or people who have tried to kill themselves, we know so many

of us, right,' she says. That includes journalists we've spoken to for this book, and that includes me.

Tanmoy Goswami speaks very movingly about his own journey with suicidal ideation, saying that 'Suicidality is absolutely a constant feature in my life.' Helping people explain some of what goes on in the mind, he says, 'Often you think of suicide as an act that is meant to relieve yourself from the burdens of the world. But what we need to understand is that suicide is also an act meant to relieve the world of you. You know, because you start imagining that you are this terrible, terrible presence that is letting down the entire world. And the world starts with your community, your family…'

It is stories like this, shared so bravely, that journalists can hope to change the narrative with.

Kalbag is also no stranger to suicide—in his case, the loss of a close friend 12 years ago to suicide, and the survivor's guilt he still feels. His is the 'why' and motivation for more empathy in our reportage—the need for more in the newsroom and in our lives. 'You know, you saw the videos of the 9/11 fire, after the plane struck the building. There was a man who fell from the building, he's called the falling man. He took that step because he didn't know what to do. He was being suffocated by the fire on the one side and… The only escape that he saw was jumping from the 89th floor… We are in that kind of a falling man syndrome, we don't know… Because we are suffocated by pressures, whether the social pressure, mental health pressure, we don't know. After all of that, the only escape that we see is jumping out of the window. And I feel that (our) endeavor—as a journalist,

as mental health professionals, as society—should be, can we remove the suffocation within the room, so that the person does not have to jump out of the building to find an escape route?'

He adds, 'For the guilt that I've been living through for the last 10 years… What could I have done to understand (name withheld)'s problems at the right time, so that I could have made the room easier for him to breathe. You know, and so that he didn't have to jump out of the window.'

The tragic is so personal. There is a human face, a human family behind each tragedy. Which makes it imperative for journalists to choose their words carefully, to share the stories you find, sensitively, humanely, and with empathy. Learn the guidelines, don't follow the tried and tested (and horrific) path that is causing so much distress—use phrases like 'died by suicide' rather than 'committed suicide' and remember that your words matter.

If we could remember to ground our reporting in empathy, we could help prevent so much damage. We could ask ourselves, *What is the story about, really? Does it need these details? Are they just salacious or sensationalist? Is there something else I should be focusing on?*

Clearly, just like there are style guidelines that each media house follows, which individual journalists have to keep in mind, the globally reputed and recommended guidelines on suicide reporting should be made mandatory to follow in-house. Kalbag knows how tough it is to implement these guidelines though, because of the number of gate-keepers in the system, which is why he also makes a call for 'institutional' rather than 'individual' change. The only way to

scale impact, is for media organisations to decide that they will not look at this as business as usual, he says, talking about media across radio, digital media, print and TV. ‘The second thing is not look at patients of mental health with sympathy, we need to look at them with empathy,’ he says. ‘This is something that needs to be taught early on to editors in all newsrooms. Not to speculate on the reasons for suicide, not to judge folks who have attempted suicide, but instead to look at issues, like why someone didn’t have access to mental health treatment, for example? And how can we, as reporters and editors plug that gap… without being vultures?’

He would go the step beyond, saying the question to ask is, ‘Can we help those people because of our access to mental health professionals, you know, at least in some way, try and help, family members who are affected by this.’

The Challenge of Reporting Responsibly

Now, if you’re a journalist in India, you hopefully have a better sense of the incredible responsibility and power you wield—in the case of suicide, your work can literally save lives. It all comes down to how you report on suicide. With the Covid-19 era, following which experts are predicting an impending suicide crisis, it’s clear that this time will prove critical and we need a new kind of reporting, that not only humanizes but empathizes.

The story-telling has to change to foreground voices and stories of survivors of suicide loss, survivors of suicide attempts. These are clearly the voices which need to be

amplified, if anything is to change in our understanding, collective narrative and ability to save lives. Maybe if reporters, editors, and social media influencers alike, remembered that each story, each statistic, is a human life lost, and that each media report is influencing countless others, maybe that could help get the point across. Raashi Thakran, a survivor of suicide loss, has spoken openly about losing her 18-year-old brother Raghav to suicide. Her point is simple and straightforward, 'The media plays such an important role; don't glamourize, don't sensationalise. Follow the guidelines, don't talk about the method (of death by suicide),' she tells us.

It's also a good idea for newsrooms to ensure a core team (encompassing all gate-keepers) which conducts a mandatory Suicide Reporting training module that includes required reading of the WHO or Press Council of India guidelines. This is an area that needs sustained attention and investment, if the fourth estate is going to live up to its role and name.

There also needs to be more domain expertise—move the reporting responsibility away from the crime beat, if not to the health beat, then to reporters and editors who are looking at agriculture, society at large, and socio-cultural determinants. Social welfare reporters will know the importance of highlighting socio-economic conditions that can often play such a pivotal role in this extreme step. Rural reporters will have a wealth of sources and access to stakeholders who can make a difference on the ground, and can also push for change themselves, by highlighting the human side of the crisis and even the success stories—cases

where highly lethal pesticides have been restricted leading to a reduction in suicide.

Overall, it is critical that we work to change the narrative of suicide as a single-factor decision by an individual who may have a mental illness (which as you will have read in this book, is often *not* the case in India) to a complex, multi-factorial issue with social determinants playing a critical role. We need to look at systems, infrastructure, financial institutions, the failure of basic organisations that are letting our people (young and old, alike) down. We need reporters to sniff out the stories, follow the data and do what they do best.

Let's go beyond the narrative of 'psychiatrist / mental health expert'-led pieces speculating on causes for suicide. As Sandhya Menon told us—there's way too much jargon there.

The power of the human story is profound. And what's also inspiring is how change can happen, conversation by conversation, story by story. Dr Vijayakumar shares that she has good interactions with the media, who play a critical role, and even mass media. She worked with soap opera producers in Tamil Nadu like A.V.M. Saravanan and others, when realising that many Tamil serials would show a woman dousing herself in kerosene and setting herself on fire when facing a domestic crisis.

She is planning more research that will look into the Papageno phenomenon, whereby media reporting can be influential in a positive way—in preventing suicide by showing other alternatives. The phenomenon is based on a character from Mozart's *The Magic Flute.*

‘Just as there is a Werther’s phenomenon, there is something called as a Papageno phenomenon… (which) is when you use the media to prevent suicide. See, for example, for a depressed suicidal person—if you’re able to show that people in a similar crisis have been able to resolve their life crisis in a more coping way than suicide—people are moving away from suicide. So this we call it is a Papageno phenomenon,’ explains Dr Vijayakumar.

For those of you reading this, we hope that the stories of lived experience present the alternatives, and also ways that people have found to cope. Menon shares what helped her through that difficult time of suicidal ideation. ‘I cut the world out, stuck to a routine and therapist’s advice…’ Cutting off a large part of the world included a ‘judicious use of social media’. Her advice to others who might be thinking of suicide or struggling with suicidal ideation, apart from seeking professional help is to: ‘Find a visual cue to look at (more concrete advice). Wait it out. It will pass. Allow yourself the chance to wake up (less concrete).’ She found a soft board useful.

Movingly, Goswami—who writes so eloquently on mental health from a social justice and human rights lens, and digs deeper than most to share the acutely personal (and often painful)—says that what helped him deal with suicidal ideation is fatherhood. ‘It is not my child’s job to “save” me. The last thing I’d like to do to him is to convey that he has to be my protector. That’s a terribly unfair burden to place on a child. But it is true that fatherhood has directly and indirectly brought me back from some really scary places.’

Media in India: Is there Hope?

Kalbag is clear that change has to be institutional and that the time is now. 'I think between 2019 and 2022 those are the three or four years that are really important for making that change. We will face a lot of frustrations because I know that it requires a huge one, you know, 180 degree mindset change in terms of approaching these issues. But it's got to be done.'

Is there hope for change or any precedent we can look at?

Goswami writes in this article for the site I set up called The Health Collective,[1] 'History shows that real change can happen surprisingly quickly. Between 1984 and mid-1987, the subway system in Vienna saw a sharp increase in suicides.[11] The beleaguered city introduced guidelines for responsible media reporting, and just as dramatically, there was a 75% decrease in the rate of subway suicides and a 20% decrease in the overall suicide rate in Vienna. *Training journalists to report responsibly on suicide and imposing of media blackouts on suicide reporting have both been found to be effective*[12] *in population-level suicide prevention.'*

He strikes a positive note for India. 'Can we expect this kind of discipline from the Indian media, with its reputation for noise and bombast? Apparently we can. When researchers[13] working on mental health trends in Asian media asked whether it would be possible to persuade the media in India to accept recommendations for reporting on suicide, they found that the answer was "yes".'

From the number of journalists I've had the privilege of interacting with, to an increase in media attention to 'mental

health' more broadly, given the pandemic, I think that positive note is justified—though we do have a long way to go.

For anyone reading this who is interested, I can say that doing a gate-keeper training and any form of psychosocial first-aid course (many of these are online) can prove helpful—at the very least, I learned the importance of empathetic listening, as well as responses that are not helpful (for example, trying to point out to someone that they 'shouldn't talk like that', or 'look at all that you have going for you'.)

I have also had the privilege of hearing from several people, who have chosen to share their stories (some of which you will find on The Health Collective, and some of which are too personal to share). For anyone who is feeling distressed or interested in adding a shortlist of Indian helplines to their reporting on suicide or suicide prevention, you can refer to the list we have up on The Health Collective at www.healthcollective.in/suicide-prevention-helplines.

CHAPTER NINE

RE-INVENTING OUR WORLD

The World Health Organization encourages countries to have a suicide prevention policy and strategy. In its 2014 report entitled 'Preventing Suicide: A Global Imperative',[1] the World Health Organization says, 'The creation of a national response provides a rallying point for bringing together a diversity of stakeholders in suicide prevention and for building on their expertise through a participatory approach. The result is a convergence of stakeholders from government, NGOs, and health and non-health sectors that can contribute to country-specific, national long-term strategies that follow a public health model.'

Despite the publication of this report in 2014, and the fact that India accounts for nearly a third of world suicides, India does not have a national suicide prevention policy or a national suicide prevention strategy. Two states (Kerala and Gujarat) have a suicide prevention policy and Chhattisgarh has a suicide prevention strategy. However, these policies and strategies have largely remained on paper with very little effort at implementation.

India's first National Mental Health Policy in 2014[2] has suicide prevention as one of the strategic areas of action. However, there is little to no effort at implementing any of the strategies outlined in the policy.

What explains this total lack of policy action by the union and state governments?

As one policy-maker put it, ‘And even then, with all of these interventions and programs, it is not conceivable that the majority of suicide deaths will be prevented.’ This appears to be one of the major stumbling blocks to getting policy-makers to act. Even senior policy-makers, against all the evidence, do not believe that the majority of suicides can be prevented. This may partly explain the inertia to develop, implement, and evaluate suicide prevention policies.

When we interviewed Duleeka Knipe, a suicide prevention researcher, born in Sri Lanka, raised in Hong Kong and currently working at the University of Bristol, she said, ‘I think, there is this idea that it’s inevitable sometimes, that people will, you can’t stop them. If they want to do it, they’ll go ahead and do it. They’re going to die by suicide, they’re going to make an attempt on their life. And there’s a little bit of fatalism around that. And, I think that needs to shift, desperately needs to shift because we’re not going to get anywhere if that is what people think. Because it’s simply not true.’

Politicians and bureaucrats are generally reluctant to be associated with any suicide prevention policy because of how success and failure are defined (an absolute absence of suicides due to a suicide program) and their belief this is unlikely to happen. After all, who wants to champion a losing cause? One way of addressing this issue is to change the public discourse to suicide *reduction* programs rather than suicide *prevention* programs.

There is another belief amongst policy-makers that suicide prevention is a mental health problem. This is not only limited to policy-makers but is a general belief in our society.

This means that suicide prevention programs have the burden of double stigma, one that is associated with mental health and another associated with suicides. If you ask any policy-maker (or a member of the general public, for that matter) for suggestions to prevent suicides they will immediately mention a few things—helplines, counsellors in schools and colleges and, if they are a bit more sensitive, the need to treat depression.

As Duleeka Knipe says, 'A lot of the evidence that's out there often comes from high-income countries where maybe mental disorders are really a strong predisposing factor for suicide. But, in contexts like Sri Lanka, that doesn't play out so well. That's not to say that mental disorder isn't on the causal path. Social factors can obviously lead people to develop mental health issues. We need to treat that and we need to identify that. However, you can treat somebody for depression and anxiety but if they are living in a household with extreme violence, you know that's not necessarily going to reduce their risk of suicide, or self-harm. So it's important to challenge that focus on mental disorders, try to shift it and change the lens a little bit to refocus on social determinants being important as clinical factors.'

In the rest of this chapter, we will explore these two questions: Can suicide reduction programs actually reduce suicides, and can this be achieved by focusing on sectors other than the health sector? What policy interventions may have significant impact on suicides (or attempted suicides) in India?

The first step to knowing whether a suicide reduction program actually works, requires good quality data. In India,

the data on suicides is collected by the National Crime Records Bureau (NCRB), which essentially collates data from all State Crime Records Bureaus across the country. The State Crime Records Bureaus collate data from the various district police commissionerates in the state, who in turn collect the data from the individual police stations under their jurisdiction. So essentially, what is recorded as a suicide ultimately boils down to what the police constable in the local police station will record as suicide. This may sound surprising, but we do know from evidence around the country that many suicides are recorded as accidents for various reasons— stigma, fear of criminal prosecution, and the need to claim insurance are just a few examples.

Depending on which study one relies upon, the NCRB data underestimates suicides by anywhere from 30 per cent[3] to 75 per cent.[4] So the actual suicides in India each year may range from 135,000 to 260,000.

In our research, we also found that suicides using certain methods are easier to be mis-recorded as accidents (e.g., poisonings, drownings) while other methods are less prone to being misclassified (e.g., hanging). The NCRB data over many years also consistently shows that hanging as a method of suicide accounts for about 45–50 per cent of all suicides while poisonings account for about 25–28 per cent and drownings account for about 5 per cent or less.[5-8] Our research shows that poisonings are much more, but because they are prone to misclassification, they appear to account for a small proportion of method used for suicides in the NCRB data.

The absence of a good quality suicide recording system means it is difficult to assess the effectiveness of any suicide reduction program. Furthermore, no government or centralized agency at the state or national level collects data on attempted suicides in India. If you ask any researcher working in the field of suicide prevention for the number of attempted suicides in the country, they will say they do not know. The best ‘guesstimates’ for attempted suicides is based on what we know from other countries. In most other countries, attempted suicides are 4–20 times the number of suicides.

If we were to calculate this for India, based on the NCRB data, this would translate into 520,000 to 2.5 million attempted suicides each year. Since we know the NCRB data is an underestimation, these numbers are likely to be even higher. Using the Million Death Study this would translate into a 30 per cent higher range, between 700,000 to 3.25 million suicides. If you decided to rely on the WHO & Global Burden of Disease data, it would translate to 1 million to 5 million attempted suicides each year across the country.

You will see this is a very broad range from 0.5 million at the lower end to 5 million attempted suicides at the higher end. Similarly, the suicide numbers as discussed above range from 130,000–260,000 suicides depending on which data is closer to the real number. It is, therefore, impossible to estimate the success (or failure) of a suicide and attempted suicide reduction program without accurate data.

Hence, the first and foremost policy requirement is putting in place a good quality suicide and attempted suicide registration system. This is no rocket science—many

countries including ‘poor’ countries (low- and middle-income countries) have done this successfully. For a suicide and attempted suicide registration system to function it has to be combined with a registration system for accidents as many suicides and attempted suicides are misclassified as accidents. Further, the determination of whether any accidental death is a suicide or an accident should not be left to the police constable, but should be established on the basis of psychological autopsy for each and every such death. This may sound like a tall order, but we are looking at approximately 500,000 such psychological autopsies per year. This is not the place to get into the merits and demerits of a psychological autopsy and how and who should run such a system but suffice to say that this is eminently doable.

In June 2021, the WHO published *Live Life: An Implementation Guide for Suicide Prevention in* Countries.[9] One of the four key recommendations of this manual is to limit access to means of suicide.

Research shows that most people who attempt suicide or die by suicide are ambivalent about dying and many attempts and deaths are usually an impulsive response to an acutely stressful event or situation. In such circumstances, limiting access to lethal means of suicide may not prevent an attempt, but will certainly prevent morbidity (hospitalization) and death. There is also evidence to show that reducing access to one means of suicide does not necessarily lead to increased use of other means of suicide, at least in the short term.

In the USA, this means limiting access to guns. In India and most of South Asia, limiting access to lethal means of suicide

translates into limiting access to pesticides and insecticides. Pesticides vary in their lethality and toxicity and the focus is on removing (by banning) or limiting access to the most toxic and lethal pesticides, and not all pesticides used in agriculture and allied areas.

By the 1980s, Sri Lanka had one of the highest rates of suicide in South Asia, with ingestion of pesticides as the predominant method of suicide. Starting with banning two pesticides in 1983, Sri Lanka banned almost all WHO Class I pesticides (which are the most hazardous) in 1995. Over the next 20 years, suicides in Sri Lanka fell by over 70 per cent —from 57 per 100,000 in 1995 to 17 per 100,000 in 2016. What's equally impressive is that the ban did not have any impact on agricultural production in Sri Lanka during this period.

A similar effect was seen in South Korea, where a paraquat (a pesticide) ban in 2012 was responsible for more than half of the reductions in suicide between 2011 and 2013.

Being an island country with little local production of pesticides, implementing a ban and thus controlling availability was relatively easy to do in Sri Lanka. But limiting access to the most lethal pesticides does not only mean banning certain pesticides. There is also a need to look at safe storage of other less toxic pesticides. Safe storage strategies did not work in Sri Lanka but are undergoing trials in India. SPIRIT (Suicide Prevention & Implementation Research Initiative) is a program which in collaboration with local panchayats in Mehsana district in Gujarat is installing storage boxes in the panchayat offices. Farmers in the villages are encouraged to keep all pesticides in these

storage boxes which are free to use. Results of this trial and its effectiveness in reducing suicides and attempted suicides using pesticides should be known in the next two to three years.

Implementing any ban on certain toxic pesticides identified by WHO will necessarily require the involvement of a range of stakeholders including local farming communities, panchayats, pesticide producers, national regulators and local and national politicians.

The next example of how policy changes can significantly impact suicides comes from India. Lakshmi Vijayakumar from Chennai is a suicide prevention researcher with an international reputation. Dr Vijayakumar shares this interesting anecdote. Many decades ago, after visiting the Samaritans in London she returned to Chennai. 'I wanted to come back and start something like Samaritans here. However, there was complete skepticism and criticism from everybody. They said, "Madras is really conservative. People won't come, and then you can't expect to run an organization only with volunteers. You have to have professionals to handle this. Can you really prevent suicide? You're going to fold up within a year."'

SNEHA, the organization she founded, and which started one of India's first suicide prevention helplines, is now 35 years old. It is run entirely by volunteers and is true to its founder's vision.

About 20 years ago, SNEHA volunteers noticed the number of calls increased in June each year. June is typically the 'board results' season in India. 'We were working from morning till night,' Lakshmi says. 'We kept the Centre

(SNEHA) open for 24 hours a day. During [exam] results time, the number of students who were calling increased three to four times.'

Lakshmi continues, 'So we did some research on the young people who died by suicide and we found they belong to two subsets. One was people who wanted very high marks and got something below their expectation. But a sizable portion were people who failed in one or two subjects by a few marks.'

So Lakshmi began a campaign lobbying the state government in Tamil Nadu to bring in supplemental examinations whereby students could re-take the examination within two months and not lose an academic year.

In 2004, Tamil Nadu introduced the supplemental exam for 10^{th} and 12^{th} Boards. Students who had failed up to three subjects could immediately take a supplemental exam and if they passed in this exam, they could continue their studies with their classmates.

Fifteen years later, Lakshmi says, 'These suicides now are 50 per cent of what it was before. From 400, they have come down to 200–230 although the number of students taking these exams has increased manifold. For Chennai it used to be 50–60 students dying because of exam failure. Now, it is significantly lower, I mean 10–20, like that.'

A third and final example of the inter-sectoral nature of suicide reduction comes from Brazil and Indonesia. The 'Bolsa Familia' Program (BFP), a poverty alleviation program, has been implemented in Brazil since 2004. BFP is a conditional cash transfer program with three components

—an income supplement for those below a poverty threshold, free access to health and education.

The Brazilian Government maintains a database of approximately 114 million Brazilians (covering nearly half of Brazil's population) who have benefited from this program from 2004 to 2015. Researchers combined this data with data from other government registries such as death registers to study the impact of BFP on suicides over 12 years from 2004 to 2015.

As compared to people with similar backgrounds, those who received the BFP cash benefit, were 61 per cent less likely to have died by suicide. Even more impressive was the finding that the reduction in suicides was more prominent in women and young people below 24 years.[10]

A similar cash transfer program in Indonesia, targeted at the poorest 10 per cent of the population, found an 18 per cent reduction in suicides amongst the recipients.[11]

The above examples highlight a few important points. These are not health sector interventions or what are traditionally recognized as health sector programs. The reduction in suicides is highly impressive—from 50 per cent for the supplemental exams in Tamil Nadu to 60 per cent for the conditional cash transfer program in Brazil to 70 per cent by banning toxic pesticides in Sri Lanka. There are hardly any mental health sector treatments or prevention programs which have such impressive results as these non-health sector interventions.

A justified criticism from many suicide prevention researchers working in countries like India and other low-and-middle income countries is that most suicide prevention

recommendations are based on findings in rich countries of Europe and North America. However, the findings described above are from programs implemented in low-and-middle income countries, and therefore highly suited for India. Especially as India has a huge shortage of trained mental health professionals and therefore mental health services are not easily available.

A final point is these programs require significant policy changes and cannot be implemented without support from regional and national policy-makers. Lakshmi Vijayakumar says, ‘Some of the other states like Maharashtra and Karnataka have followed this supplemental exams system, we are trying to make it across all of India, but they say education is a state subject and each state has to decide.’

Lakshmi Vijayakumar has the last word when she says, ‘There is no simple reason why a person dies by suicide. It is a medical issue, it is a psychological issue, it’s a social issue, it’s a cultural issue.’

CHAPTER TEN

ME FIRST

Adjust Your Own Oxygen Mask First

When we spoke to Professor Vikram Patel about myths surrounding suicides, he said that the biggest myth is that this is entirely the result of individual factors. He said, 'Of course, a suicide is a highly individual act, the final act of killing yourself is one that only an individual can take. But to assume that the individual is acting as a free agent, that the individual has chosen to end his or her life independent of factors in their social world is simply incorrect. This fact is unfortunately translated in our penal code to accusing a particular person who may have "abetted" the suicide. If there really was an abetment case, it should be against those who actually perpetuate the policies which create the toxic social circumstances, for example the right-wing hate groups who terrorize inter-caste or inter-faith couples.'

In line with this argument, a lot of our book has focused on the systemic problems that can push people to dying by suicide, but in this chapter, we try to focus on the possible solutions at the level of individuals. One could argue that this is a bit of an anomaly considering that we spent a lot of energy in this book postulating the greater role of systemic causes for suicide in India. So, before moving forward, let us disabuse ourselves of the notion that suicide in India results only from systemic factors. There is a fraction of the

population, however small, that dies by suicide due to factors that reside in the individual and which might work independently or in consort with systemic issues. Additionally, even in situations where circumstances around us are the distal driving forces leading to death by suicide, many times they work mechanistically through individual level changes (e.g., feelings of hopelessness). This brings hope to prevention efforts which can otherwise feel nihilistic in the face of the monumental challenges in making fundamental changes to our ecosystem to reduce suicide rates in our country. So, while we continue our efforts to make the larger systemic changes, we also need to continue working at the level of the individual to reduce the risk of suicide.

Human beings are generally good at stating the problem, and this comes easily to us. When it comes to formulating solutions, we falter. However, there is no escaping the fact that appropriate responses can be devised only when there is an adequate understanding of what it is that we are trying to resolve. We can recognize signs in what people experience, in what they say (which in turn might be a vocalization of what they experience) and what they do. In being able to recognize these in ourselves or in others, we might be in a position to help ourselves and others. This chapter is an attempt to summarize some of the steps that individuals can take to help themselves or others when they experience distressing suicidal thoughts, and the myths that might interfere with help-seeking or providing support.

The Myths

A lot of what many people experience as a part of everyday life stressors overlaps with symptoms of mental health problems, which makes it difficult to separate one from the other. Let us take the example of depression to illustrate the point. As much as ‘depression’ is a much misused term in lay conversation, ‘clinical depression’ as understood by mental health professionals involves experiences (e.g., low mood, loss of interest) that are sustained, intense and usually interfere with day-today functioning. That does not mean that one cannot intermittently experience one or more of the symptoms of depression in the absence of ‘clinical depression’. The absence of a clinical diagnosis neither invalidates these experiences nor reduces the pain that they cause. So, even in the absence of a ‘mental disorder’, one might experience a low mood, unexplained loss of interest in activities that previously used to give pleasure, unexplained anxiety, an inner restlessness, and a feeling of helplessness and/ or hopelessness about one’s own ability to change what is happening in their life or how they are feeling. It is not difficult to understand why such experiences will be distressing enough for someone to consider suicide. However, there are paradoxical instances when people have been reported to have been actually improving in how they were feeling before ‘inexplicably’ dying by suicide. The former, i.e., visible and sustained distress, might be easier to spot and hence possibly easier to respond to. The latter, i.e., a positive change or improvement, is understandably bound to breed a sense of complacency and can lead to missing out on an impending disaster. This abrupt and uncharacteristic calm after a period of distress (mistaken as an improvement)

can come on as a result of the individual having made the decision to kill themselves, and stems from the belief that their impending death will finally solve their overwhelming problems—the stereotypical calm before the storm. Hence, one needs to be watchful of such sudden improvement or any abrupt reduction in distress; and be guided by Voltaire's 'Doubt is not a pleasant condition, but certainty is absurd.'

The assertion that people take their own life 'out of the blue' is simply not true. Most people who find themselves to be vulnerable to ending their lives communicate their distress directly or indirectly. Although many times the act of suicide might appear impulsive, it is anything but that. In fact, most people who die by suicide are in a crisis situation and hence are not in a mental space to spontaneously generate a specific plan to end their life, unless they have already thought about it in the past. The final action is usually preceded by substantial mental and physical preparation, and this time leading up to suicide may be marked by several indications of intent. Thus, what appears to be a sudden act to the outside world is actually something that has often developed over time and through deliberation has moved through stages such as ideation, planning, and attempt. That is not to say that impulse plays no role in suicide. It is especially relevant in young people, who may not yet be fully adept at processing, managing, and expressing their emotions, and among whom impulsive acts are considered a legitimate means of communicating distress.

An extension of the 'out of the blue' myth is that someone who has their act together is not at risk of suicide, and when

that does happen it takes everyone by surprise. The deaths of Robin Williams, and more recently of Sushant Singh Rajput in India, seemingly happy and successful individuals, are high-profile examples that put paid to this belief. The bottom-line is that just because someone appears to have it all—a great job, a healthy family, an active social life—does not mean that they will not contemplate suicide. What we see is the veneer and we do not really know what is going on inside the person's mind.

A counter-point to this are the people who directly or indirectly talk about their intent to die by suicide. Ironically, while they might be talking about it because they are asking for help, they do not get the help they want because of the mistaken belief that 'there are talkers, and there are doers'. Such talk about wanting to end one's life should not be ignored as, no matter how casually or fleetingly communicated, it may indicate serious suicidal ideas and intent. It is very important to take them seriously because, as we now know, many people who die by suicide have very often directly or indirectly indicated to someone that they want to die.

Many times, individuals who experience these feelings/emotions will also vocalize them. The explicitness of the vocalization might vary from direct references of wanting to kill oneself, to relatively more subtle indications of not having a reason to live, right up to the lot more non-specific feelings of being trapped or being a burden to others. Finally, in some individuals the intent to die by suicide might become obvious not through what they say but through their behaviour. Some of these behaviours might be directed

towards ending their life and others might be much subtler intentional or unintentional communication of their intent. The former includes actions which are potentially dangerous, such as reckless driving and increased use of drugs or alcohol. The latter might include the much more subtle withdrawal from activities and isolating from loved ones, searching online for methods to kill oneself, and putting their personal business in order such as visiting friends and family members to say goodbye, giving away prized personal possessions, making a will, and cleaning up their room or home.

Many times, in the absence of any obvious external signs, the only way to access a person’s inner world is to talk with them about it. Unfortunately, we remain afraid of broaching the subject of suicide with a vulnerable person, for fear that we might plant the idea in their head. But the reality is that the person who is struggling with thoughts of suicide may be relieved to have the opportunity to share their disturbing thoughts with someone else. Just as asking someone about chest pain cannot make them get a cardiac arrest, asking someone about suicidal thoughts cannot make them want to end their life, however difficult their circumstances. For many people, being asked about suicidal thoughts opens the door to openly express and understand their feelings better, relieves their anxiety, and is often the first step to getting help. Most people thinking of suicide want help, but do not talk about it because of the stigma, and also because they do not know who to talk to. So, starting the discussion allows the weighing of options and introduces the opportunity to suggest means to help with the situation.

Raashi Thakran, who lost her younger brother to suicide, works hard at busting many of these myths around suicides and one that she especially feels strongly about is the belief that talking to someone about suicide plants the idea in their head. She says, ‘That couldn’t be further from the truth. This is something that I’ve experienced first-hand. When I go to a school and I ask them if I can conduct a workshop on suicide prevention, they are not sure if I should do that. They say that these are kids, if you talk about suicide, it might just trigger them, or encourage them to think more about it. Honestly, it’s quite the opposite. If you talk to someone about suicide, you create a safe space, you start the conversation where that person feels comfortable enough and trusts you enough to open up. Most importantly, it can save lives. So that’s definitely a myth that I really wish that we can sort of chuck out of the window.’

All through this book we have been at pains to stress that all suicides are not due to underlying mental health problems, and this is especially and peculiarly true for India, where unlike the West, a large proportion of suicides are driven by systemic issues. We would be remiss not to highlight one more time that it is untrue that only people with mental disorders die by suicide, and in fact it would be extremely reductive to connect suicide to mental disorders alone. This is especially true in a country where many suicides are explained by deep distress and vulnerabilities due to social pressures such as job loss, financial crisis, exam failure, and relationship breakdown.

One cruel interpretation of people dying by suicide is that they are selfish and take the easy way out by ending their

lives. Nothing can be farther from the truth. Ending one's life is anything but easy. People who die by suicide do not go down that route because they do not want to live; they do so because they want to end their suffering. For people who die by suicide, their emotional suffering is so strong or their circumstances so difficult that they feel utterly helpless and hopeless in the face of such seemingly intractable challenges.

Another common belief is that once a person is intent on suicide, there is no way of stopping them. This is a nihilistic belief which precludes the possibility of helping anyone with thoughts of suicide. In a country with such high rates of suicide, a false belief such as this can cause paralysis right from the individual who can help to the policy-maker who can create systems that reduce risk of suicide. Both the intent and impulse to die by suicide fluctuates between wanting to die and the desire to live. Nothing can illustrate the latter more starkly than the evidence that contact with health care services prior to suicide is common and 80 per cent of those who die by suicide have been in contact with health care services 12 months prior to suicide.[1]

Multiple suicides have been observed in some families. The simplest, and possibly the laziest, explanation is that suicide is hereditary. But the reality is far more complex than that. While families share genes, they also experience greatly similar emotional and social environments. Thus, difficult life circumstances experienced by one family member are likely to be experienced by others in the family as well. Additionally, the coping methods and styles exhibited by some family members may also be mirrored and learnt by others

in the family. Hence, more than genes, it is the shared difficult life circumstances combined with modelling of observed behaviours that is responsible for multiple instances of suicide in the same family.

Helping Ourselves

We know for a fact that the resources to help someone experiencing suicidal thoughts are limited in India. While we try to bring about a change to that systemic limitation, we cannot allow the prevalent conditions to handicap us. Although a lot of answers lie in systemic change and formal help, there are several things that we can do to take care of ourselves if we are experiencing situations that are making us consider dying by suicide as the only way out. Professor Patel gives us hope when he says that there are steps we can take as individuals to help ourselves, 'My main message is, first of all, recognize that almost every human being will, at some point in their life, experience feelings of hopelessness and despair. The most important thing to remember is that the overwhelming majority of those people's lives ultimately acquire meaning and purpose. And so never ever lose hope. Even when things look bleak, give yourself time and they will improve. Above all, do not act on impulse, just pause, think, and talk to someone. And you will soon find that you were glad that you didn't take the step.'

One of the first things to do when feeling suicidal is to find a safe space or make one's immediate environment safe. This could entail removing items from one's home that could be used to hurt oneself, such as tablets or razors. However,

if making the environment safe is simply not feasible then the alternative would be to remove oneself from that space by going somewhere else for a while. If one chooses to go to a friend or family member, it is important to be direct and explain the situation to them rather than assuming they will automatically understand what you need.

It may be tempting to relieve emotional pain or to forget one's difficult circumstances by using drugs or alcohol. Although this might feel like a simple solution, it is actually a bad idea for several reasons. First, instead of helping, these substances could make the situation worse as they are likely to intensify your low mood and enhance the feelings of helplessness and hopelessness. Furthermore, alcohol and some other drugs can lower our inhibitions and increase impulsivity, thus making it more likely that we will act on our feelings and plan to die by suicide.

Building a supportive network around oneself means that one does not have to deal with a crisis on one's own. It helps to have a network of people in your life that you can confide in and such relationships built on trust are protective. This network could be made up of one or more family, friends, and members of the community such as one's church group, or a club or sports team.

Raashi emphasizes the importance of being able to find someone with whom one can share one's distress. 'You're not alone, if you are in a distress situation, there are people out there who are here to help you, they really care about you. There are trained professionals whose job is to help you get through these difficult times. So, reach out to a trusted individual. It could be your parents, if you're not close to

your parents, let's say it could be a sibling, or a best friend, or teacher maybe. But find that one person and just reach out and talk about it. Because sometimes just talking about it can make a world of a difference. And it can really help bring things into perspective. And you will get through this, it will take time, but with the right kind of support, you will get through it. The important thing to do is for you to reach out, because no one else can really get into your head and know what's going on in there. So, unless you speak up, unless you talk about it, unless you give out some sort of a sign, people will just not be able to understand or help you out. So, I think that's the thing to do. Just talk about it or just reach out to someone you trust.'

CONNECTING NGO HELPLINE

{for those in emotional distress or feeling suicidal}:

9922004305 | 9922001122 (all days, 12 pm—8 pm)

For email support, write to: distressmailsconnecting@gmail.com

Connecting NGO also offers a listening service that is confidential, anonymous, non-judgemental, and non-advisory.

Web: www.connectingngo.org

In the contemporary world, some of these networks could be virtual social networks which allow connecting with people beyond geographical boundaries. While seeking support from such networks, it is important to keep in mind that not everyone understands suicide and when talking to them it is important to let them know how they can help.

Often, just sharing how one feels helps. Sometimes, that might not be sufficient and one might have to reach out to a mental health professional for formal help. If that feels too daunting, one could seek the help of a trusted friend or family member to help you find and contact one. Bottom line —when in doubt, reach out.

For Tanmoy Goswami, this support network turned out to be social media. He heaps praises on his 'Twitter family' while describing how it helped: 'I have got more validation and more kindness from them than from any other source. And so yeah, I can't overemphasize the role that Twitter has played in my healing. It has been just the most incredible space. I mean, all these people, I know them all from Twitter, and they have come together to hold me at various times and you know, really create a sense of safety around me. Yeah, that community is something that I think a lot more research needs to be done on just how, you know, Twitter in particular helps, sort of, the process of healing.' Social media has been much vilified for contributing to increasing harms, especially amongst young people. However, as with most complex phenomena, the connection between social media and mental health is not black and white. Social media use can adversely affect mental wellbeing, expose users to hostile communication, and can result in adverse consequences on employment and relationships. On the other hand, social media can also have positive impact on mental wellbeing by allowing opportunities to connect with others by overcoming barriers of time and geography, enabling peer support by individuals who have themselves experienced mental illness and provide support to others facing similar experiences,

acting as a repository for mental health information, and helping connect with appropriate healthcare providers and programs that provide services directly over social media.

Some other things that have been known to work include positive self-talk (e.g., finding one's reasons to live, telling oneself that one can get through the difficult time, concentrating on the positive things in life), developing coping strategies that work for oneself, allowing oneself to feel one's feelings as suppressing them can cause them to build up over time and make them even harder to deal with, spending time with others doing things that one enjoys, building self-esteem (e.g., writing down one's achievements and the things one likes about oneself, however small), and regularly making time to do things just for oneself.

Sometimes, these strategies to help oneself might not work or may not be sufficient by themselves. When this happens, it is important to seek professional help. One could consult a range of mental health professionals such as a psychiatrist, psychologist or counsellor. One could also choose to speak to someone through crisis helplines where one can get support from trained people, usually available 24x7. The key is to seek help in a timely fashion.

Helping Others

Most of us will get through life without directly coming across someone who is feeling suicidal. However, there are some of us who will meet just such a person, and when we do, we cannot afford to be caught off guard. Sometimes that one interaction might be the one which makes a difference to

someone’s life. It is not easy to interact with someone you care about when they want to harm themselves. However, it is important to remember that you do not have to be a health professional to help someone you are worried about; just reaching out and connecting with them could make a difference.

When, where, and how you have that conversation with the person you are worried about is very important. Such conversations need a calm environment and might take a long time; so it is important to choose a place where you can talk openly without getting interrupted, and to ensure that you do not have other commitments that will distract you. This conversation could be had while both of you are doing something you enjoy doing together, or even going for a walk or drive together. The key is to create an environment where both of you are feeling comfortable and relaxed enough to delve into a topic which might be painful to discuss.

Your job is to keep the conversation going through open-ended questions, be empathetic and non-judgemental, reassuring them that it is okay to talk about their feelings and that you are there to help, offer hope, and most importantly, just be prepared to listen. Such active listening includes giving them all of your attention, avoiding interrupting, focusing on their words, and asking for clarification if there is something that you do not understand.

While your support can make a big difference, sometimes professional support is an important way forward and hence you might have to suggest that as an option. It is quite possible that they might resist the idea of therapy but it is important to keep encouraging them to reach out. One way

of doing that is to demystify the process by talking over what happens in therapy and also addressing concerns, which many times are around being labelled as having mental health problems, being hospitalized, and being forced to take medicines. Helping them connect with supports and resources in their communities, and indeed, exploring some of these with them allows them to develop a safety plan which includes what to do and whom to contact in a crisis.

Finally, after this initial conversation, make sure to follow-up to see how they are doing. This could be in person, or through a phone call, or even a simple text message. This is a crucial way of continuing to show feelings of connectedness between you and them, and of expressing your ongoing support for them.

Just as it is important for us to know what to do to help someone who is feeling suicidal, it is equally important to know what not to do. Whatever you do, do not start judging their suicidal thoughts or behaviours, and do not take things personally if they do not want to talk about their feelings at that moment. Keep encouraging them to talk about it. So, ask, and keep asking. Sometimes you might be tempted to entirely avoid the topic believing that encouraging them to think about other things will help them feel better. However, shying away from the topic does not help and might make them interpret your avoidance as discomfort with talking about suicide, and they might stop confiding in you believing that you do not recognise their distress.

As human beings, when confronted with someone having problems, our instinctive reaction is to offer quick solutions. This should be avoided in situations where we are trying to

help someone who is struggling with thoughts about suicide. It is not our conceptualisation of the size of the problem that matters, it is how big they perceive it to be that counts. In such a case, what we think are rational arguments do little good and what matters is being compassionate and non-judgemental. Instead of jumping straight into giving advice, what is more helpful is just 'being there' and this includes being physically present for someone, speaking with them on the phone, and showing support.

While emphasizing the importance of reaching out for help, Dr Vijayakumar also warns us of the perils of not listening and rushing into giving advice. She says, 'So my message to people who may be suicidal is to reach out for help. There will be somebody who is willing to listen to you and who is willing to understand you. However, when they reach out for help, the other people don't even listen properly. They give this kind of advice: "Look at people who are worse than you"; or if they are sympathetic, they will say "Take a couple of days break, go somewhere."'

Finally, remember that it is absolutely normal to feel scared when confronted by someone who is feeling suicidal. It is also possible that you might not understand what they are feeling, but even when that happens do not minimise or invalidate their distress. Although, as individuals, we might be not responsible for preventing someone from ending their own life, our timely intervention may help them to appreciate other alternative options that are available to them.

Suicide is not an inevitability. There are steps we can take to help ourselves if we are feeling suicidal; and there are things we can do to help others who might be feeling so.

Sometimes our erroneous beliefs about suicide and lack of knowledge about what we could do interfere with our intent and ability to help ourselves and others. Correcting these misconceptions and employing a range of strategies that are known to work could go a long way in enhancing the societal responses to reducing suicides in the country.

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